Oregon's Health Care Cost Growth Target Program

Data Specification Manual (CGT-2)

Version 5.0, for September 2025 data submission

June 11, 2025

OREGON HEALTH AUTHORITY

HEALTH CARE COST GROWTH TARGET

About

In 2019, the Oregon Legislature passed Senate Bill 889, establishing Oregon's Health Care Cost Growth Target Program and the Implementation Committee to select the cost growth target and design an implementation plan. The Implementation Committee submitted their recommendations to the Legislature in January 2021 and the state is now implementing the program.

Each year, the state will report on health care cost growth relative to the cost growth target at four levels: for the state overall, for each insurance market (Medicaid, Medicare, commercial), for each individual payer, and for large provider organizations. To do so, the state will need to collect data from a variety of sources, including annual data submissions from payers.

This manual provides the technical specifications to assist payers in preparing the annual health care cost growth target data submission. This document accompanies the Cost Growth Target Data Submission Template (CGT-1) and supplemental files.

This document is organized as follows:

- An overview of how the cost growth target will be calculated at each of the four levels and the data sources needed for each.
- A description of which payers need to report data and how other data will be obtained.
- The data submission timeline and process.
- A detailed description of the fields in the data submission template and specifications for what should be included in each.
- Appendices including a data dictionary and provider taxonomy codes.

Standardization vs Payer Customization

Payers must follow the specifications for the data submission outlined in this document to ensure a standardized approach; however, there are several places where payers have flexibility in how they prepare the data for submission. Recognizing that systems payers use to report and analyze data vary, these opportunities for customized approaches are indicated throughout this document with this icon.

For More Information

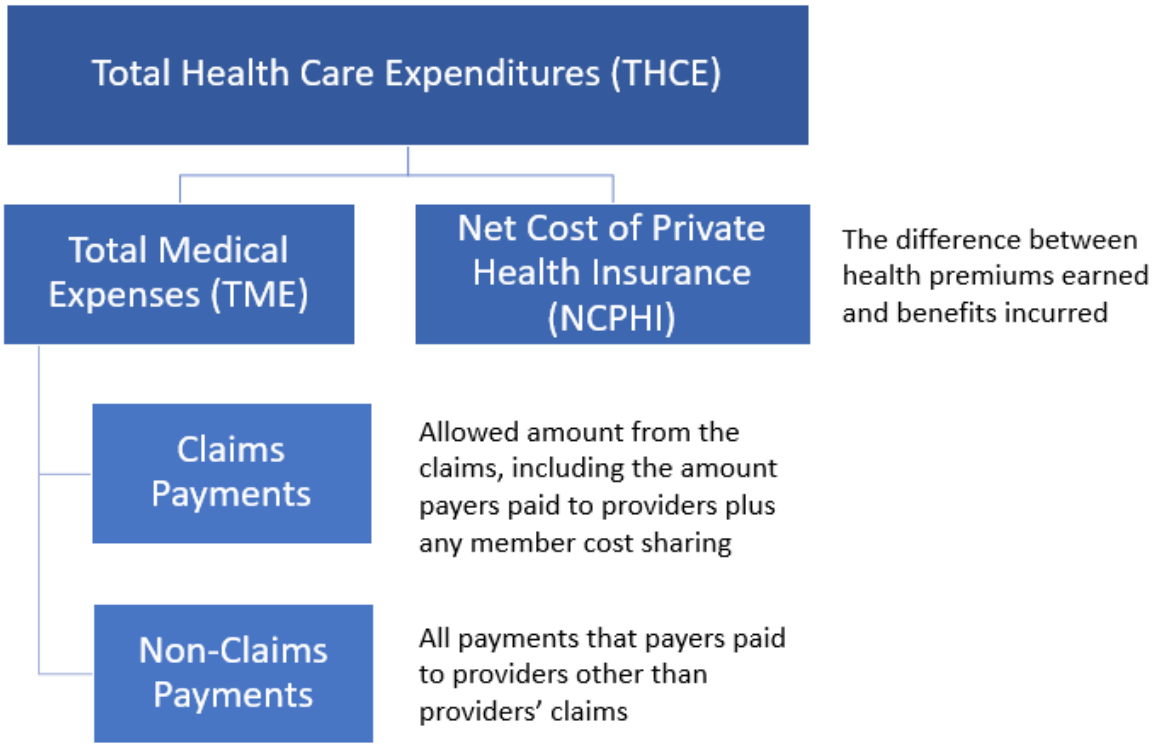
Contact HealthCare.CostTarget@oha.oregon.gov
Forms and other reference documents available online at:
https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

Table of Contents

Calculating Performance against the Cost Growth Target

Oregon's Health Care Cost Growth Target Program measures the annual per capita rate of growth for Total Health Care Expenditures (THCE) in the state. THCE is defined as the allowed amount of claims-based spending from an insurer to a provider, all non-claims-based spending from an insurer to a provider, the Net Cost of Private Health Insurance (NCPHI), and Other spending. See Appendix F: Glossary for definitions.

Figure 1. Components of Total Health Care Expenditures



TME is reported net of pharmacy rebates

Oregon will measure THCE on an aggregate dollar and per capita basis. The aggregate dollar amount will be for informational purposes only. The change in THCE and Total Medical Expenses (TME) on a per capita basis will be used to assess performance against the cost growth target.

Oregon's health care cost growth target is calculated and applied at four different levels:

1. Statewide
2. By Market (Medicare, Medicaid, commercial)
3. By Payer
4. By Provider Organization

The annual per capita rate of growth is measured differently for these levels, as different components of THCE apply. THCE will be reported per capita at the state level but will be reported on a per member per month (PMPM) basis at the market level. TME and NCPHI are reported separately on a PMPM basis at the payer level. TME is reported on a PMPM basis at the provider organization level. References to "per capita" throughout this document could also indicate PMPM for certain levels of analysis. See Table 1, below, followed by Table 2.

Statewide and by Market

Annual cost growth is measured and reported as THCE per capita at the statewide and market levels. At the statewide level, THCE is calculated as the sum of (1) TME net of pharmacy rebates, (2) NCPHI and (3) Other spending[1]. THCE per capita can be written as:

$$THCE\ per\ capita\ = \frac{(TME\ minus\ pharmacy\ rebates) +\ NCPHI + Other\ spending}{Denominator}$$

The denominator for THCE per capita differs slightly for each level. See Table 1.

Table 1. Denominator for THCE Per Capita Calculations

Level	Denominator
State	Total Oregon residents enrolled in a health plan under one of the three main markets, plus the number of individuals receiving care from Veterans Affairs and the Oregon Department of Corrections.
By Market	Member months of the total Oregon residents enrolled in a health plan in a given market, statewide. Member months are divided by 12 to approximate the number of individuals.

[1] Other spending includes spending on medical care by Veterans Affairs, the Oregon Department of Corrections, and the Oregon State Hospital. It also includes spending on other behavioral health contracts by the state and the NW Pharmacy Purchasing Program.

While the percent change in THCE per capita is what will be reported and compared to the cost growth target at the statewide level, trends in TME and NCPHI are reported separately to provide context. Note that NCPHI does not apply to Medicaid Fee-For-Service data reported by OHA, nor to Medicare Fee-For Service data reported by the Centers for Medicaid and Medicare Services (CMS). See Table 2.

Table 2. Components of Total Health Care Expenditures (THCE)

Level	THCE components		Reported as		Report trends for	
	TME	NCPHI	Aggregate $	Per Capita	TME	NCPHI
State	X	X	X	X	X	X
Market: Medicare	X	X	X	X	X	X
Market: Medicaid	X	X	X	X	X	X
Market: Commercial	X	X	X	X	X	X
Payer	X			X	X	X
Provider Org.	X			X	X	

By Payer and Provider Organization

At the payer and provider organization level, annual cost growth is measured and reported as growth in TME PMPM for each accountable market. Accountable markets align with line of business (LOB) codes: Medicare (Advantage) – LOB 1, Medicaid – LOB 2, and commercial (full claims) – LOB 3. TME includes all payments made to provider organizations by payers (both claims-based and non-claims-based), and patient cost sharing. See Appendix F: Glossary for definitions.

$$TME\ PMPM\ = \frac{Claims\ payments^{2} + Non\text{-}claims\ payments}{Total\ member\ months\ (Payer)\ or\ Total\ attributed\ member\ months\ (Provider)}$$

To measure TME at the provider organization level, payers will attribute members to a specific provider organization using a primary care-based attribution method. Not all of a payer's members will be attributed to specific provider organizations. See the following Attribution section.

[2] Claims payments include the amount payers paid to providers and any member cost sharing.

The TME PMPM calculation includes a demographic adjustment for population age and gender status. Demo-adjusted TME PMPM can be written as:

$$Demo-adjusted\ TME\ PMPM\ =\ \frac{\frac{Claims\ payments}{demographic\ score}+Non\text{-}claims\ payments}{\begin{matrix}Total\ member\ months\ (Payer)\ or\\ Total\ attributed\ member\ months\ (Provider)\end{matrix}}$$

See the following Demographic Adjustment section for additional details.

Additional Details

The following technical details are applicable for all levels of analysis: statewide, market, payer, and provider organization.

Included Population

THCE and TME are inclusive of spending on behalf of Oregon residents who are insured by Medicare, Medicaid, or commercial insurance, and receive care from any provider in or outside of Oregon. Out-of-state residents who receive care from Oregon providers are not included.

In the case that a payer offers student health plans for universities in Oregon, students insured through these plans should be counted as Oregon residents for the duration of the plan coverage, regardless of whether their permanent residence is out of state.

Calculating Net Cost of Private Health Insurance

The Net Cost of Private Health Insurance (NCPHI) is calculated separately for the different segments of Oregon's health insurance markets. The methodology for each market segment is described below.

Commercial – Fully Insured Market

For the commercial fully insured market (including individual, large group, small group, and student plans), NCPHI is calculated from the federal commercial MLR reports, where

$$\begin{aligned}NCPHI = {} & Premium\ as\ of\ March\ 31\ (Part\ 1, Line\ 1.1)\\ & - Total\ Incurred\ Claims\ as\ of\ March\ 31\ (Part\ 1, Line\ 2.1)\\ & - Advance\ Payments\ of\ Cost\ Sharing\ Reductions\ (Part\ 2, Line\ 2.18)]\\ & - MLR\ Rebates\ Current\ Year\ (Part\ 3, Line\ 5.4)\end{aligned}$$

Note NPCHI is net of MLR rebates.

Commercial – Self Insured Market

For the self-insured market, NCPHI is calculated using additional data submitted by self-insured payers on the income from fees of uninsured plans. Payers with self-insured

lines of business must provide total premiums received for self-insured accounts (in aggregate). See Tab 1. Cover Page in the Data Submission Template (CGT-1) and the Data Dictionary in Appendix B for more details on what to report.

Medicare Advantage Organizations

For the Medicare Advantage market, NCPHI is calculated from the Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners, where

$$NCPHI = Premium\ as\ of\ March\ 31\ (Part\ 1, Line\ 1.1) - Total\ Incurred\ Claims\ as\ of\ March\ 31\ (Part\ 1, Line\ 5.0)$$

Medicaid Coordinated Care Organizations

For Medicaid Coordinated Care Organizations, NCPHI is calculated from the Exhibit L reports collected by OHA, where (from the Consolidating Quarterly Statement of Revenues and Expenses)

$$NCPHI = Gross\ Premiums\ (Capitation\ \&\ Case\ Rate\ Revenue)\ (Line\ 1) - Member\ Service\ Expenses\ Subtotal\ (Line\ 17)$$

NCPHI

Payers are required to report the number of member months for each market segment in their CGT-1 file, and the numbers will be used to calculate NCPHI on a per capita and PMPM basis, where

$$NCPHI\ per\ capita = \frac{NCPHI}{Member\ months/12}$$

To get NCPHI applicable to Oregon residents, NCPHI PMPM must first be calculated using in-situ information from a payer's premium, claims, and member month data from either the SHCE or MLR. Next, this NCPHI PMPM will be multiplied by each payer's member months reported in their CGT-1 submission to get NCPHI for Oregon residents within each market segment. By using member months reported in the CGT-1 data, OHA will assume the cost of administering private health insurance for Oregon residents is the same for the payer as it is for their non-Oregon members.

Attribution

Payers must use a primary care-based attribution method to attribute their enrolled Oregon resident members to specific accountable entities. Primary care attribution should be made, whenever possible, to entities that meet the CGT guidelines for accountability.

Accountable entities are organizations that provide primary care services for the member and/or have contracting arrangements with the payer. For example, a provider organization can be an accountable entity if they provide primary care services;

however, there can also be an Independent Physician Association (IPA) associated with that member for contracting purposes. In this situation both entities may be accountable for the associated costs of the member.

A **provider organization** is defined as the highest organization level (i.e., hospitals, health systems, medical groups, federally qualified health centers, etc.) that employs or contracts with the patient's primary care provider in the relevant timeframe. Wherever possible, payers should roll all costs up to the provider organization level (as opposed to the clinic or TIN level) and include the provider organization's name in the "Provider Organization Name" field of the TME_PROV, PROV_ID and RX_MED_PROV tabs. Additional specifications for reporting on costs at the IPA or Contract level are included in the *Provider Organization or Contract Designation* section below.

Note the data reported for each provider organization must include all Total Medical Expenses (TME) for attributed members, even when these members were receiving care from providers outside of their attributed provider organization.

Attribution includes both member choice of provider and methodologies to attribute a member to a specific organization based on utilization or other factors. Not all members will be attributed.

Payers may use their own attribution methods, as long as they follow the attribution hierarchy described below. Payers must report their primary care attribution methods to OHA, and OHA may request additional information from payers about their attribution methodology. OHA reserves the right to ask payers to modify their attribution methods if needed.

Member Attribution Hierarchy

As cost growth trends may be different for members who chose their provider (tier 1) and members who were attributed to an accountable entity based on a contract arrangement or utilization (tier 2 or 3), payers must report them in separate categories in Tab 3. TME_PROV of the Data Submission Template (CGT-1). Payers must attempt to attribute members using the three tiers below, in hierarchical order:

Tier 1 **Member selection:** Members who were required to select a primary care provider or a primary care home by plan design should be assigned to that PCP's provider organization (i.e., the highest-level entity that employs or contracts with the PCP).

Do not include members who were automatically assigned a primary care provider by the payer with no member input into or approval of the selection. Payers who are unable to distinguish members who selected or approved their own primary care provider from those who were automatically assigned a provider should see if they can assign a primary care provider based on tier 2 or tier 3, and if not, include these members as unattributed.

In cases where the auto-assignment of a PCP is for the purposes of determining capitation payments (e.g., as with many CCOs), members should be attributed to those PCPs under Tier 2.

Additionally, if a member has the choice of plan design and selects a plan with limited primary care provider options ("narrow network"), that member and their costs should be included in tier 2 attribution. Note not all narrow network plan designs have limited primary care provider choices and not all members enrolled in these plans should be assigned to tier 2 attribution by default.

Tier 2 **Contract arrangement:** Members not included in #1 who were attributed to a primary care provider or a primary care home during the measurement period pursuant to a contract between the payer and provider, should be attributed to that provider organization. For example, if a provider is engaged in a total cost of care arrangement that assigns to them a specific member population for primary care services, then the payer may use its attribution model for that contract to attribute those members.

If the contracted entity is an IPA that does not provide primary care services, then the payer should attempt to identify the member's primary care provider and include that provider in the Provider Organization Name field in the TME_PROV, RX_MED_PROV and PROV_ID tabs. This may involve identifying the provider organization using a utilization algorithm. For guidance on what value to include in the attribution tier field in this case, see the flow chart in Appendix D.

Tier 3 **Utilization:** Members not included in #1 or #2 who can be attributed to a primary care provider or a primary care home based on the member's utilization, using the payer's own attribution methodology.

Utilization-based attribution methods should only attribute each member month and associated costs to one provider organization at a time.

Payers should attempt to align utilization-based algorithms with reporting on attributed populations that has been shared with provider organizations wherever possible. Payers who use tier 3 must provide a summary of their methodology in Tab 1. COVER_PAGE.

Members who cannot be attributed to primary care providers, a primary care home, or another accountable entity (IPA, etc.) using any of the three tiers above should be reported in aggregate to Tab 4. TME_UNATTR, as "unattributed members."

Payers are responsible for rolling up (affiliating) primary care providers to provider organizations using their own methodology. Members may be attributed to more than one primary care provider, primary care home, or another accountable entity during a calendar year.

If the primary care providers are all affiliated with the same accountable entity, the member and their corresponding total medical expenses (TME) would be attributed to that accountable entity – regardless of any change in primary care providers.

If members are attributed to more than one primary care provider or primary care home during a calendar year and the providers are affiliated with different accountable entities, their TME should be mutually exclusively allocated to each of the accountable entities, based on the respective member months allocated to each accountable entity.

If a provider organization row in Tab 3. TME_PROV has a member month value ***less than or equal to 12***, payers must transfer this data to the appropriate row in Tab 4. TME_UNATTR.

Reporting Attribution Example

Suppose in 2024, Payer A has a total of 12,000 member months attributed to Hospital System Z in the line of Commercial: Full Claims. Out of the 12,000 member months, 3,000 are assigned to Hospital System Z by member selection (tier 1), 4,000 are attributed to Hospital System Z because of contract arrangement (tier 2), and 5,000 are attributed to Hospital System Z based on the members' utilization (tier 3).

Payer A would enter these numbers in Tab 3. TME_PROV (TME: Member Months Attributed to Provider Organizations) in the Data Submission Template (CGT-1) like the table below. The demographic scores, expenses and standard deviations of these member months would be reported into 3 separate rows accordingly.

Reporting Year	Line of Business Code	Provider Organization Name	**IPA or Contract Name (if applicable/available)**	Attribution Hierarchy Code	Member Months
2024	3	Hospital System Z		1	3,000
2024	3	Hospital System Z		2	4,000
2024	3	Hospital System Z		3	5,000

Suppose in 2024, Payer A has a total of 6,000 member months in the line of Commercial: Full Claims that cannot be attributed to any provider organization or other accountable entity based on the attribution hierarchy, then all the 6,000 would be reported in one row in Tab 4. TME_UNATTR (TME: Unattributed Member Months) like the table below. The demographic score, expenses and standard deviation of these member months would be reported into one row in aggregate accordingly.

Reporting Year	Line of Business Code	Member Months
2024	3	6,000

In 2024, Payer A has a total of 18,000 member months in the line of Commercial: Full Claims, where 12,000 of them are attributed to Hospital System Z and 6,000 of them are not attributed to any provider organization. Payer A would report all 18,000 member months in one row in Tab 2. TME_ALL (TME: All) like the table below. The demographic score, expenses and standard deviation of these member months would be reported into one row in aggregate accordingly.

Reporting Year	Line of Business Code	Member Months
2024	3	18,000

Provider Organization Attribution

Payers should attribute members to primary care providers using the guidance in the prior Member Attribution Hierarchy subsection. Those primary care providers will have Taxpayer Identification Numbers (TINs) associated with their practice or organization, and large health systems or other provider organizations may have multiple TINs.

Where possible, payers should report one provider organization in each row of Tab 3 of the Data Submission Template, which would represent the sum of all of its affiliated TINs. For example, Hospital System Z has six TINs associated to it, each belonging to a primary care practice. In Tab 3, report the total experience of Hospital System Z in one row rather than the experience of the individual six TINs separately.

In Tab 9, report all of the associated TINs and names for each of the provider organizations listed in Tab 3. Using the same example as above, in Tab 9 payers would report Hospital System Z and identify all six affiliated entities by their TIN and entity name. If Hospital System Z is not a part of a larger IPA or contract to which their lives should be attributed, the IPA or Contract Name field (PRV03) can be left blank.

If a payer cannot group TINs together because they lack the data to understand how the providers are organized, please report the data by TIN in Tab 3.

IPA or Contract Designation

A cost growth target provider organization (populated in the “Provider Organization Name” field of TME_PROV, RX_MED_PROV and PROV_ID) is defined as the highest organizational level that employs or contracts with a member’s primary care provider in the relevant timeframe. The IPA or Contract Name Field was added to the CGT-1 data submission template in order for payers to provide additional information about entities that sit in between the payer and provider. These entities sometimes work with or include representation from more than one provider organization and may be involved in activities ranging from contracting and rate negotiation to population health management. These entities may be accountable to the cost growth target.

The CGT-1 data submission template allows payers to indicate when a member or provider organization is associated with one of these entities. Examples of such entities include:

- A group of providers forms an IPA, which negotiates those providers' rates with a particular set of payers.
- A value-based payment (VBP) contract is developed by a large provider organization on behalf of that organization and an alliance of smaller organizations. The organizations all work together on managing their population's health and receive value-based payments based on their participation in the contract, though their fee-for-service rate schedules are negotiated independently of the contract.
- A payer contracts with an outside entity that provides population health services for a subset of the payer's members and holds a risk-based contract with the payer that is paid out based on certain health metrics of the member population. Members visit different primary care providers, and the intermediary entity may have some involvement in helping them to negotiate their contracts with the payer.

In some cases, the payer may have detailed information about payments made to these entities, including what members are associated with the payments and who their PCPs are. The intended use of the IPA/Contract Name field is for the payer to provide this detail to OHA so that costs can correctly be attributed to both the provider organization and the intermediary entity, since both of these entities may have a role in managing members' costs and care.

Filling out this field is required. If a payer does not have the available data to complete this field, please contact OHA to discuss prior to the data submission due date.

Using the IPA/Contract Name field

Attribution of member months usually starts at the level of the provider organization that employs the member's PCP. If the payer has additional information about that provider organization's association with an IPA or contracting mechanism involved in managing their population's cost of care, or about the member's association with such an entity independently of their provider organization, they should also fill out the IPA or Contract Name field.

Note that the value of the Attribution Tier data field should include the tier through which the member was attributed to their PCP's provider organization, *not* the tier that might be associated with the intermediary entity, unless the payer only has information about attribution to the intermediary entity.

Attribution Example 1: Both Provider Organization Name and IPA/Contract Known

Suppose Independent Physician Practices X, Y, and Z are participating in a Total Cost of Care contract where they negotiate shared contract terms with a payer and work together to meet certain quality metrics. They also have other contracts with the same payer where they negotiate different payment terms for a set of patients. Each of these independent physician practices will have two lines in the PROV_ID tab and the TME_PROV tab, with and without Total Cost of Care Contract A filled in.

The payer attributes patients to the independent physician practices based on Tier 2 because the shared Total Cost of Care Contract A designates what patient populations are attributed to each organization, and the mix of patient population characteristics determines the capitation payment rate these practice receive for that population. The payer is able to attribute additional members to these provider organizations based on member PCP selection (Tier 1) and member utilization (Tier 3).

Tab 9. PROV_ID

PRV01	PRV03	PRV02
free text	free text	text
Provider Organization Name	IPA or Contract Name (if applicable/available)	Provider Organization TIN
Physician Practice X	Total Cost of Care Contract A	000000001
Physician Practice Y	Total Cost of Care Contract A	000000002
Physician Practice Z	Total Cost of Care Contract A	000000003
Physician Practice X		000000001
Physician Practice Y		000000002
Physician Practice Z		000000003

Tab 3. TME_PROV

TMEPRV03	TMEPRV04	TMEPRV06
free text	free text	text
Provider Organization Name	IPA or Contract Name (if applicable/available)	Attribution Hierarchy Code
Physician Practice X	Total Cost of Care Contract A	2
Physician Practice Y	Total Cost of Care Contract A	2
Physician Practice Z	Total Cost of Care Contract A	2
Physician Practice X		1
Physician Practice Y		1
Physician Practice Z		3

Attribution Example 2: Only IPA/Contract Known for Some Members

In County X, the payer works with an entity that holds a risk bearing contract for managing the health of the county's membership (Total Cost of Care Contract B). This entity does not employ PCPs that provide care but offers other services to the population like care coordination and health education.

A portion of the county's membership has claims activity with the major provider organization, Provider Organization A, so the payer is able to attribute those members to Provider Organization A through attribution tier 3. Both these members and the remaining members for whom the payer has no additional attribution information are covered under the contract with the population health management company under Total Cost of Care Contract B.

The payer includes all members in the county in two lines in TME_PROV, one with attribution to Provider Organization A in the Provider Organization field using Tier 3, and one with Total Cost of Care Contract B included in both the Provider Organization and IPA or Contract Name field.

The line with Total Cost of Care Contract B in both fields designates members with no known PCP but who are covered under this contract. Since no PCP provider is known, the payer attributes these members instead to the contract using Tier 2. There is no contract-specific TIN that is known to the payer, so they include a placeholder TIN in the Provider Organization TIN field in PROV_ID.

Tab 9. PROV_ID

PRV01	PRV03	PRV02
free text	free text	text
Provider Organization Name	IPA or Contract Name (if applicable/available)	Provider Organization TIN
Physician Practice A	Total Cost of Care Contract B	120938405
Total Cost of Care Contract B	Total Cost of Care Contract B	999999999

Tab 3. TME_PROV

TMEPRV03	TMEPRV04	TMEPRV06
free text	free text	text
Provider Organization Name	IPA or Contract Name (if applicable/available)	Attribution Hierarchy Code
Physician Practice A	Total Cost of Care Contract B	3
Total Cost of Care Contract B	Total Cost of Care Contract B	2

Defining Primary Care Providers for Attribution

Payers who are developing or modifying their own primary care attribution methodology (for Tier 3 in the attribution hierarchy previously outlined) must use the provider taxonomy codes from the Primary Care Spending Reporting Program (SB 231, 2015) to identify primary care providers. See Table 3 below.

Table 3. Primary Care Taxonomy Codes and Descriptions

Taxonomy Code	Description
364S00000X	Certified clinical nurse specialist
261QF0400X	Federally qualified health center
175L00000X	Homeopathic medicine
175F00000X	Naturopathic medicine
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health
363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatrics
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
163W00000X	Nurse, non-practitioner
207Q00000X	Physician, family medicine

Taxonomy Code	Description
207R00000X	Physician, general internal medicine
208D00000X	Physician, general practice
207RG0300X	Physician, geriatric medicine
202D00000X	Physician, integrative medicine
208000000X	Physician, pediatrics
2083P0500X	Physician, preventive medicine
363A00000X	Physician's assistant/associate
363AM0700X	Physician's assistant/associate, medical
261QP2300X	Primary care clinic
261QR1300X	Rural health clinic

Note psychiatric and OB/GYN providers are included in the Primary Care Spending Reporting Program's definition but have been excluded for the purposes of the Cost Growth Target Program's taxonomy for attribution.

If payers need additional guidance in identifying primary care services to help with attribution, OHA has also provided a set of procedure codes from the Primary Care Spending Report Program in Appendix C. Payers can also use their own internal processes for identifying primary care services.

Demographic Adjustment

Why Adjust for Demographics?

A payer or provider organization's population may change over the course of a year. Some of these changes will have an impact on spending growth, e.g., a population that is older than last year would be expected to have higher spending than the previous year.

To the extent possible, performance relative to the cost growth target needs to be adjusted for provider and payer organizations year over year to offset the natural aging and therefore cost of the population. However, at the market or statewide levels the populations are large enough to be stable over time such that demographic adjustment is unnecessary.

Demographic Adjustment Requirements

Each payer must use the demographic adjustment factors as provided in the data submission template. The factors are provided by age band, sex, and line of business and should be applied to the relevant population by the data submitting organization. Factors were developed from Oregon claims data from the All Payer All Claims Program.

- The demographic adjustment factors used should correspond to the population and program reported (i.e., Medicare, Medicaid, commercial).
- Demographic scores should reflect all Oregon residents included at the payer and provider organization levels (i.e., payers should not exclude residents from adjustment).
- Member age should be based on the age of the member at the end of the measurement period. For example, for the calendar year 2024 measurement period, the member's age at December 31, 2024 should be used to decide which age band the member belongs
- Demographic tables will be re-configured every 3-5 years or as needed based on changes in Oregon healthcare cost and utilization trends.

Demographic Adjustment Reporting

Payers will report both the unadjusted amounts and a demographic score for each row in the data submission template. OHA will calculate the demo-adjusted amounts using the unadjusted data and demographic scores provided.

Included in the attestation that the data is complete, current, and accurate is an acknowledgment that the demographic scores are tabulated using the most recent demographic tables provided in the most up to date data submission template and that the scores are themselves accurate to the best of the payer's knowledge.

Data submissions must include two years of data. Each measurement period will use the same demographic factors within the submission. No normalization is needed when applying factors to multiple measurement periods.

Demographic Adjustment Reporting in Tab TME_ALL

The demographic adjustment score reported in the TME_ALL tab is the weighted average of demographic adjustment scores reported in the TME_PROV and TME_UNATTR tabs by line of business, that is, the product of the member months times the risk adjustment scores divided by the sum of member months in a given year-line of business.

Example of TMEALL04 calculation (for one year-line of business):

- **TME_PROV tab**

Provider Organization Name	Member Months	Demographic Score
Main St Provider Group	720,000	1.15234
Hospital System Z	480,000	1.14254

- **TME_UNATTR tab**

Provider Organization Name	Member Months	Demographic Score
N/A	100,000	1.16475

- **TME_ALL tab**
  Demographic Score (TMEALL04) =

$$\frac{(720{,}000 \times 1.15234) + (480{,}000 \times 1.14254) + (100{,}000 \times 1.16475)}{(720{,}000 + 480{,}000 + 100{,}000)} = 1.14968$$

Data submitters should confirm in Table 2 of tab TME Validation that, for each combination of year and line of business, the demographic adjustment score reported in the TME_ALL tab is equal to the weighted average of demographic adjustment scores reported in the TME_PROV and TME_UNATTR tabs.

See CGT-1 with mock data for an example:
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/CGT-1-Data-Submission-Template-ver2.0-(training-mock-data).xlsx

Data Sources and Payer Reporting

Multiple data sources are needed to calculate health care cost growth each year. This section describes the different data sources, as well as which payers are required to submit data.

Data Sources

The primary source for Total Health Care Expenditures (THCE) data is the annual data submission from payers, as outlined in Oregon Administrative Rule (OAR) 409-065, but multiple data sources are used for a more comprehensive calculation of health care cost growth. OHA is responsible for collecting and compiling all data sources. See Table 4 below.

Table 4. Components of THCE Calculation by Data Source

Component of THCE	Category	Data Source
Total Medical Expenses (TME)	Payers claims payments	Payer data submission template (CGT-1)
	Payers non-claims payments	Payer data submission template (CGT-1)
	Payer enrollment	Payer data submission template (CGT-1)
	Medicaid fee-for-service claims payments and non-claims payments and enrollment	OHA
	Medicare fee-for-service claims payments and all Part D spending	CMS
	Pharmacy Rebates	Payer data submission template (CGT-1)
Net Cost of Private Health Insurance (NCPHI)	NCPHI for commercial fully-insured market	Federal commercial medical loss ratio (MLR) reports
	NCPHI for Medicare Advantage	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
	NCPHI for Medicaid Managed Care	OHA Exhibit L financial reporting
	Income from Fees of Uninsured Plans to calculate NPCHI for self-insured plans	Payer data submission template (CGT-1)
	Number of member months in each market segment for calculating NCPHI	Payer data submission template (CGT-1)

Table 4. (con.) Components of THCE Calculation by Data Source

Component of THCE	Category	Data Source
Other data sources	Veterans Affairs (VA)	National Center for Veterans Analysis and Statistics
	Oregon Department of Corrections	Oregon Department of Corrections
	Behavioral Health Services provided by additional contracts	OHA
	NW Pharmacy Purchasing Program	OHA
	Oregon State Hospital	OHA
	CCO-F	Payer data submission template (CGT-1)
	Medicaid Carve-Outs	Payer data submission template (CGT-1)
	CCO Other	Exhibit L and Audited HRS

Which Payers are Required to Submit Data?

Data submission requirements for the Cost Growth Target Program are in OAR 409-065 (filed November 19, 2021).

Mandatory Reporters

All payers and third-party administrators (TPAs) with at least 1,000 covered Oregon lives across all lines of business must submit cost growth target data. Payers will be identified using enrollment data from the Department of Consumer and Business Services (DCBS) and from OHA's Medicaid enrollment reports. OHA will aggregate the most recent four quarters of enrollment data and use the mean total lives to identify mandatory reporters for each reporting year.

If the only individually reportable line of business a payer or TPA has in Oregon is Medicare Advantage; and, if the number of Medicare Advantage covered lives in Oregon is less than five percent of the total Medicare Advantage market in Oregon, the payer or TPA will not be considered a mandatory reporter and will be invited to submit data as a voluntary reporter.

OHA will identify mandatory reporters each year and provide written notification by April 30th to all payers and TPAs subject to the reporting requirements of the current year. See the list of current mandatory reporters at the CGT Data Submission website.

If a payer or TPA believes its determination as a mandatory reporter for a reporting year is in error, they must contact OHA to contest the determination within 30 days of notification of mandatory reporter status. To contest: email HealthCare.CostTarget@oha.oregon.gov.

New mandatory reporters submitting data for the first time, or mandatory reporters that did not submit data in the previous year, will need to participate in a data submission training provided by OHA prior to their first data submission.

Voluntary Reporters

OHA will also identify voluntary reporters that have at least 1,000 calculated mean total lives across all lines of business and will invite them to participate in the annual data submission. See the list of current voluntary reporters at the CGT Data Submission website.

Which Lines of Business are Included?

Payers should only report claims and non-claims payments **made to provider organizations or other accountable entities**. Reporters shall submit data for all required lines of business (LOBs); they shall not submit data for any excluded LOBs.

Mandatory reporters that contract with another entity for any required LOBs remain responsible for reporting all required LOBs to OHA. The mandatory reporter may elect to have the contracted entity report the data but will need to notify OHA and provide contact information for the contracted entity. The contracted entity may also need to participate in the data submission training.

Required LOBs:

Included markets are **Medicaid**, **Medicare**, and **Commercial**. The Commercial LOB includes individual, small group, large group, self-insured plans, short-term health plans, and student-health plans.

Excluded LOBs:

- Accident policy
- Dental-only insurance
- Disability policy
- Hospital indemnity policy
- Long-term care insurance
- Medicare supplemental insurance (AKA Medigap)
- Specific disease policy
- Stand-alone prescription drug plans
- Stop-loss plans
- Supplemental insurance that pays deductibles, copays, or coinsurance
- Vision-only insurance
- Workers compensation

Table 5 lists other excluded items. This is a non-exhaustive list and if there are other items that payers are not sure about whether to include or exclude in the cost growth target data submission, payers should contact OHA at HealthCare.CostTarget@oha.oregon.gov to discuss.

Table 5. Excluded Items

Discounts and other member perks, such as gym membership benefits
Payer reinsurance recoveries or reinsurance premiums
CMS reconciliation payments, such as Medicare sweep or Part D
Premiums
ACA risk transfer payments
COVID-related funds that are *not* paid to providers[3]

[3] TME may include supportive funds made to providers to support clinical and business operations during the global COVID-19 pandemic. See the Non-Claims: Other category description in the Tabs 2-4 – Total Medical Expenses (TME) subsection under Data Submission Template.

Guidance for Medicaid Coordinated Care Organizations (CCOs)

Payers should include all Medicaid and CHIP expenditures across all CCO benefit categories (A, B, E, and G) in their Medicaid LOB unless specifically excluded below.

Included Expenditures

Member Services Expenses	CCOs must include all member services expenses such as hospital services, physician/professional services, substance abuse disorder expenses, mental health, prescription drugs, transportation, durable medical equipment and supplies, and other member service expenses.
Quality Pool Distributions	CCOs must include any quality pool distributions made to providers.
Dental	CCOs must include dental in their data submission, as dental is a covered benefit for Medicaid and part of the CCOs' contracts and global budgets. All CCO-F dental-only spending must be reported in LOB 7 in the TME_ALL tab.
Cover All Kids	CCOs must include all member service expenditures for individuals receiving benefits in the Cover All Kids program.
Healthier Oregon	CCOs must include all member service expenditures for individuals receiving benefits in the Healthier Oregon program.
OHP Bridge	CCOs must include all member service expenditures for individuals receiving benefits in the OHP Bridge program (formerly Basic Health Program).
COVID-19 Vaccine Settlements	CCOs must include any vaccine settlements that were paid to or recouped from providers, if applicable.
711 Drug Spending	CCOs must report any 711 costs *they* are paying. CCOs should not estimate costs for 711 drug spending for CCO members that are "carved out" and paid by Medicaid Fee-For-Service.
Health Related Social Needs	CCOs should include any health-related social needs (HRSN) payments without attributing any HRSN spending to a PCP organization. HRSN claims and non-claims should be included in the TME_ALL and TME_UNATTR tabs only.

Excluded Expenditures

Health Related Services and SDOH Spending	CCOs should exclude Health Related Services and any spending on social determinants of health. OHA tracks this CCO spending through Exhibit L and can monitor and report on it separately.
SHARE Obligations	CCOs should exclude any payments made to comply with SHARE obligations.
Qualified Directed Payment (QDP)	CCOs should exclude QDP payments received by OHA and paid to hospitals.

Data Completeness

Claims Run-Out Period

Payers should allow for a claims run-out period of at least 180 days after December 31 of the measurement year, i.e., payers should not pull the data until after June 30 of the year following the measurement year.

All claims should be reported based on the incurred date or date of service, not the paid or reconciled date. No incurred but not reported (IBNR) or incurred but not paid (IBNP) should be applied to claims.

Payers should report their overall completeness of the claims data in Tab 1 of the Data Submission Template (CGT-1). If completeness of the claims data drops below 98%, OHA reserves the right to request payers to calculate IBNR and/or provide supplemental information.

For each data submission, payers should **not** apply a “paid through date” or otherwise limit the claims runout, even when reporting data with runout periods longer than 180 days.

Non-Claims Reconciliation Period

Payers should allow for a non-claims reconciliation period of at least 180 days after December 31 of the measurement year to reconcile non-claims payments made to providers, including incentives, capitation, risk settlements, and other non-claims-based payments.

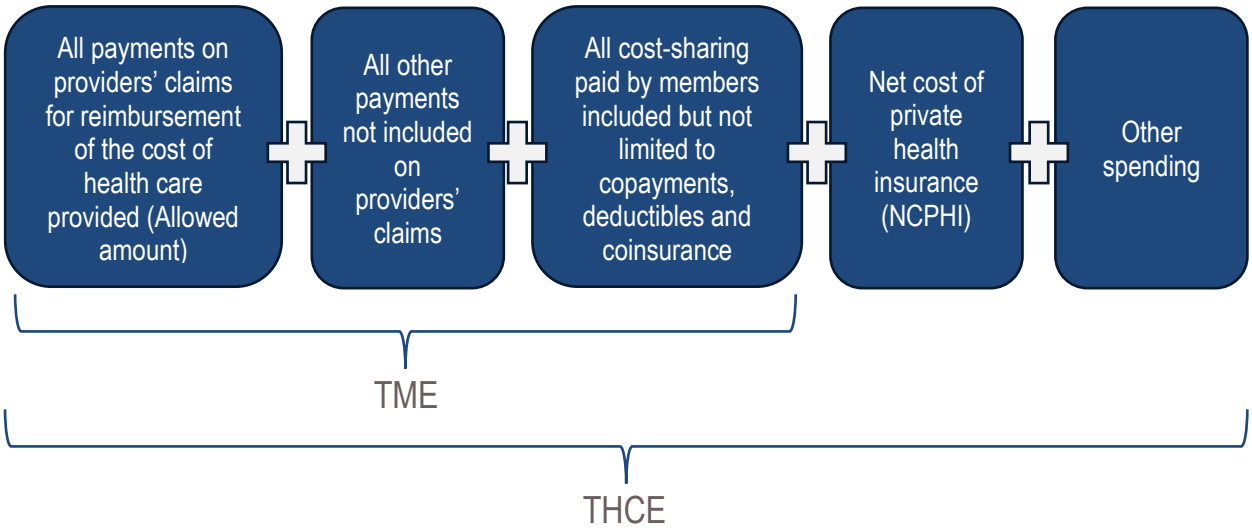
Payers should apply reasonable and appropriate estimations of non-claims liability for each provider organization (including payments expected to be made to organizations not separately identified in the reporting) that are expected to be reconciled after the 180-day reconciliation period. OHA may request additional detail from payers about their estimations.

All non-claims should be reported based on the incurred date or date of service, not the paid or reconciled date. For example, for payments made in 2024 for provider performance on a quality metric in 2023, the payment should be reported in 2023.

For each data submission, payers should **not** apply a “paid through date” or otherwise limit the non-claims runout, even when reporting data with runout periods longer than 180 days.

How Spending is Categorized

The Health Care Cost Growth Target Program is focused on measuring THCE and TME – see figure below. The data submission template captures TME, through the lens of payer to provider payments.



Claims-Based Payments

Claims-based spending should be categorized using the following broad, mutually exclusive categories. See the following Data Submission Template section for further definition.

- Hospital inpatient
- Hospital outpatient
- Professional: primary care providers
- Professional: specialty providers
- Professional: behavioral health providers
- Professional: other providers
- Long-Term care
- Retail pharmacy
- Other claims-based spending not categorized above

Non-Claims Payments

Non-claims payments are all of the payments that payers make to providers outside of claims. They should be categorized in the following way, with further definition and specification in the upcoming Data Submission Template section.

- Prospective capitated, prospective global budget, prospective case rate, or prospective episode-based payments
- Performance payments
- Shared Savings and Shared Risk Settlements
- Payments to support population health and practice infrastructure
- Payments for Health Related Social Needs (HRSN) – specific to CCOs
- Recovery
- Other non-claims-based spending

Vendors and Carved-Out Services

Some payers carve-out covered services (e.g., pharmacy and behavioral health) and may not be able to separately capture the administrative costs of carve-out vendors or have access to the claims or encounter data for these services to accurately estimate or categorize claims-based payments.

Payers should follow the general parameters below but are given flexibility in how they account for these costs because of the different approaches in how payers identify and allocate these costs.

- Spending for covered benefits should be included in the TME calculation, regardless of how the payer is delivering the benefits. If a payer is unable to determine the total spending by service category for carved-out benefits, and…
    - …has encounter data, the payer should estimate payments and include them in the TME calculation allocated to the appropriate service category.
    - …does not have access to claims or encounter data for carved-out services, the payer should apply a reasonable estimate of spending per member per service category and describe how they calculated the estimate in Tab 1 of their data submission.
- Spending on the administrative fees of carved-out vendor contracts should be included or excluded in accordance with payer reporting on federal financial forms such as the NAIC Medical Loss Ratio form.
- Spending for contracts and vendors that provide strictly administrative functions for health plan operations should not be included in the TME calculation.

Data Submission

This section describes the annual data submission timeline and process. Data submission requirements for the Cost Growth Target Program are in Oregon Administrative Rule (OAR) 409-065 (filed November 19, 2021). https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5882

Data Submission Schedule

Annual Data Submission

For annual data submission (CY 2021 data and beyond), mandatory reporters shall submit data to OHA by the first Friday in September of the reporting year. OHA will publish an updated data submission timeline each year.

Due Date	Annual Data Submission
September 5, 2025	CY 2023 and 2024 TME
September 4, 2026	CY 2024 and 2025 TME
September 3, 2027	CY 2025 and 2026 TME

OHA reserves the right to request prior year data from mandatory reporters as needed.

Waivers and Deadline Extensions

Mandatory reporters may request a waiver or deadline extension to data submission requirements.

Types of Waiver or Extension Requests	Deadline for Submitting Request
A waiver of all data submission or validation requirements	No later than 60 calendar days prior to the applicable deadline
A partial waiver of data submission requirements	No later than 14 calendar days prior to the annual reporting deadline
A deadline extension for the data submission	No later than 14 calendar days prior to the annual reporting deadline
A deadline extension for data correction, resubmission, or validation requirements.	No later than 7 calendar days after OHA requests the data correction, resubmission, or validation.

Waiver or Extension Request Approvals and Denials

OHA will approve or deny the waiver or extension request and provide written notification to the requestor within 14 calendar days of receipt of the request. OHA will only grant waivers for one data submission cycle at a time.

If OHA denies the request, the requestor may appeal the denial by requesting a contested case hearing. The appeal must be filed within 30 calendar days of the denial. The appeal process is conducted pursuant to Oregon Revised Statute (ORS) Chapter 183 and the Attorney General's Uniform and Model rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove a compelling need for the waiver.

Waiver or Deadline Extension Request Process

Reporters can request a waiver or deadline extension for an annual data submission by submitting the Cost Growth Target Data Submission Waiver / Extension Request Form (CGT-3) to OHA. Please email HealthCare.CostTarget@oha.oregon.gov to request the form.

Data Submission Process

Each data reporter should submit a single file (CGT-1) each year. One parent entity may be responsible for building multiple mandatory reporters' CGT-1 files, this is alright as long as each is submitted individually[4].

- Payers should include all required lines of business in the single file for submission.
- Payers should include all required years in the single file for submission.
- Payers will not be required to submit test data files prior to the data submission deadline.
- Data submission should follow the naming conventions and submission process below.

File Naming Conventions

Data submissions should use the following naming convention:

***Payer Name*_TME_*YYYY*_*Version*.xls**

YYYY is the four-digit year of *submission*, which will generally be one year later than the year of data reflected in the report. E.g., the data submissions for CY 2023-2024 data should be labeled "…TME_2025.xls."

The version number, though optional, is recommended and indicates the submission number, if a payer resubmits. The file extension must be .xls or .xlsx. Example: **PayerA_TME_2025_1.xlsx**

Submitting Files

Payers must email their completed Data Submission Template (CGT-1) to HealthCare.CostTarget@oha.oregon.gov.

Data Submission Confirmation

Payers will be asked to confirm details about their data submission in a cover sheet (Tab 1. Cover Page) as part of the data submission template. Payers should also provide attestation from an authorized signatory that the data submission is complete and accurate to the best of their knowledge.

[4] An exception can be made if the parent entity is responsible for multiple data reporting entities whose membership across markets (Medicare, Medicaid, Commercial) is mutually exclusive. Example: Parent Entity X is the parent entity of Payer A (Medicare Advantage only) and Payer B (Commercial only), two CGT data reporters. Since the cost growth target applies at the market level, Parent Entity X can coordinate with OHA to submit one CGT-1 file with combined Payer A & B data as the data template will differentiate spending by market and thus, the two payers.

If a payer is required to resubmit their data, the payer must have the authorized signatory re-certify the resubmission.

Validation Process

This section describes the data validation process for completeness and quality of payer-submitted CGT-1 files.

Before the cost growth analysis can begin, the payer-submitted data need to be checked for completeness and potential errors or issues. The goal of the validation process is to confirm that the payer-submitted data are accurate and able to be combined with other payer data for statewide, market, and provider organization analyses. The validation process is designed to be methodical, yet flexible, allowing for submitter-specific lines of inquiry.

The data validation process has three stages:

1. Initial review of data submission
2. Detailed review of data submission
3. Communication and finalization

Overall, **Stage 1** begins at a general level and focuses on data completeness and formatting. **Stage 2** is focused on more detailed validation of the data, such as identifying outliers in PMPMs and unexplained trend variation between years. **Stage 3** focuses on communication, with OHA reaching out to submitters and requesting a discussion of the data, including clarifications of any potential issues identified during the validation process. Stage 3 can end in two ways; the submitter may resubmit their data after correcting issues identified through the validation process, or the data submission is considered finalized and ready for analysis. Data submitters may, however, be asked for a resubmission at any stage in the validation process if issues are identified. More detail about each stage is below.

Communication points

OHA will pre-schedule data validation meetings before the submissions have been received. Depending on the readiness of the CGT files, this meeting will either focus on data clarification points (Stage 1 checks) or data discussion (Stage 2 trends, Stage 3 finalization). If OHA identifies a potential issue(s) with the submitted data, OHA will communicate with the submitter describing the potential issue and prepare validation documents for discussion. Throughout the communication process, OHA and the submitter will openly communicate and collaborate on how best to address the potential issue(s). If the potential issues have been clarified and the data deemed adequate, the resolution is considered clarified and closed. If the data are determined to be in error, the submitter will receive a Cost Growth Target Data Resubmission form describing the issue(s) and the request for new data to be provided to OHA within 15 days.

Validation checks before file submission

Before the submitter sends their completed file to OHA, the submitter should validate their data using the four auto-calculated validation tabs in the Data Submission Template (CGT-1) located after the 9. PROV_ID tab, **TME Validation**, **Provider Check, RX_MED_PROV Validation, and RX_UNATTR Validation**. These four validation tabs contain several Stage 1 checks that OHA performs. This allows the submitter to identify any potential issues before submission. OHA requests that the submitters check their submission for the following, prior to initial submission and each resubmission:

- Confirm tab 1. Cover Page is complete and attestation provided by an authorized signatory.
- Confirm there are no invalid data (red cells) in their Data Submission Template (CGT-1)
    - The cell's shading will turn red if the data do not meet the format expected.
    - Applicable to tabs 2. TME_ALL through 9. PROV_ID
- Confirm all years of data requested are included in the Data Submission Template
- Check that all tabs have been appropriately completed and tabs 1-9 are not left blank
    - Some submissions may not have all tabs 2-9 completed based on the provided markets and structure of the payer organization. For example, if all members can be attributed to a provider organization, there should not be any data in tab 4. TME_UNATTR.
- Check **TME Validation** tab tables for any potential data quality issues. Multiple tables are included in the tab:
    - Table 1 checks whether there are any rows in tab 3. TME_PROV with Member Months under the MM threshold by year and by line of business. If a provider organization row in tab TME_PROV has a member month value *less than or equal to 12*, data submitters must transfer this data to the appropriate year & LOB row in tab 4. TME_UNATTR. If there are non-compliant rows in TME_PROV, the table provides the count of rows and the cell will turn red requiring correction.

- Table 2 checks the relationship between the data in tabs 2. TME_ALL, 3. TME_PROV and 4. TME_UNATTR for the member months and all service categories (e.g., Claims: Hospital Inpatient or Non-claims: Prospective Payments). The relationship between the 3 tabs is based on the formula TME_ALL = TME_PROV + TME_UNATTR. Cells that are not colored pass validation. Cells that are red indicate that the value in TME_ALL is larger than the value of TME_PROV+TME_UNATTR. Cells that are colored blue indicate that the value in TME_ALL is smaller than the value of TME_PROV+TME_UNATTR. If a cell is colored and the discrepancy value is a few cents (e.g., $0.02), then it can be assumed that the data passes validation due to a minor rounding error.
- Table 3 checks the relationship of the demographic scores between TME_ALL, TME_PROV and TME_UNATTR. The demographic scores in TME_ALL should be a weighted average of the demographic scores in the TME_PROV and TME_UNATTR data. This table uses additional calculations in the Weighted Risk auto-calculated tab. Cells that are not colored pass validation. Cells that are red indicate that the value in TME_ALL is larger than the value of TME_PROV+TME_UNATTR. Cells that are colored blue indicate that the value in TME_ALL is smaller than the value of TME_PROV+TME_UNATTR. If a cell is colored and the value is very small (ex 0.001), then it can be assumed that the data passes validation due to a minor rounding error.
- Table 4 checks the relationship of the member month data in the TME_ALL and MARKET_ENROLL tabs at the line of business and market enrollment category level. The lines of business in TME_ALL and market enrollment categories in MARKET_ENROLL are broken down differently but align to 4 larger market-level groups: Medicare, Medicaid, Commercial, and Duals. Cells that are not colored pass validation. Cells that are red indicate that the value in TME_ALL is larger than the value of MARKET_ENROLL. Cells that are colored blue indicate that the value in TME_ALL is smaller than the value of MARKET_ENROLL. If a cell is colored and the value is very small (e.g., 1), then it can be assumed that the data passes validation due to a minor rounding error.
- Table 5 calculates the percent of each claims category that is made up of medical pharmacy costs. Payers should review these percentages to identify any cases in which the percent of a claims category made up of medical pharmacy costs seems higher or lower than might reasonably be expected.

- Check the **Provider Check** tab for any potential data quality issues. There is one table in the Provider tab that compares the Provider Organization Name data in TME_PROV to the Provider Organization Name in PROV_ID. For every provider organization listed in TME_PROV, there must be at least one corresponding row in PROV_ID. The values in the first column are auto-populated from TME_PROV. The values in the second column are auto-populated from PROV_ID. Cells that are not colored red, pass validation. If a cell in the second column is colored red and contains “NOT IN PROV_ID” then that provider organization name was present in TME_PROV but not present in the PROV_ID tab. The comparison of the two tabs is based on a perfect match, so the related organization names in both tabs *must be the same*. The submitter can scroll down the entire list of unique provider organization names to see any cells in the second column are colored red. If there are any red cells in the second column AFTER the last unique provider name row, then those can be ignored as they are an artifact of the auto-calculation used in this check.
- The costs in the TME_MED_PROV and TME_MED_UNATTR tabs should be a subset of the costs in the TME_PROV and TME_UNATTR tabs respectively. Check the **RX_MED_PROV Validation** and **RX_MED_UNATTR Validation** tabs for any rows in the medical pharmacy tabs that don’t have a corresponding line (same year-LOB-provider-IPA-attribution level) in the TME_PROV and TME_UNATTR tabs respectively (indicates that the values of those rows are not a subset of the costs in TME_PROV or TME_UNATTR). The tabs also flag cases where the value in a given cell in the TME_MED_PROV and TME_MED_UNATTR tabs is larger than its corresponding cell in the TME_PROV or TME_UNATTR tabs. For example, if the claims paid for medical pharmacy hospital outpatient services for Provider A’s patients in 2024 in LOB 2 and attribution tier 2 is $39,000 but the total outpatient costs for Provider A’s patients in 2024 in LOB 2, attribution tier 2 are only $30,000, the medical pharmacy costs are not a subset of the overall costs.

  Note that the RX_MED_PROV Validation tab may erroneously link lines in RX_MED_PROV to the wrong line in TME_PROV if there are “duplicate” lines in either of these tabs (ie, lines with the same year-LOB-provider-IPA-attribution level that occur more than once within either of these tabs). All lines in RX_MED_PROV and TME_PROV should be unique at this level. A validation check is included in each of those tabs to flag if there are any duplicate lines where costs need to be collapsed down into a single line. Once this is fixed, any erroneously flagged lines in RX_MED_PROV Validation should disappear.

Stage 1: Initial Review

1A

OHA confirms receipt of the data file and highlights the pre-scheduled meeting date/time with the submitter to discuss potential data clarification points (Stage 1 checks) or data discussion (Stage 2 trends, Stage 3 finalization).

OHA conducts a cursory review of the excel file to confirm that there are no large data quality issues that would greatly impact the validation process. These preliminary checks include, but are not limited to:

- Tab 1. Cover page has all necessary responses and attestation completed
- No invalid data present in the submission (indicated by red colored cells)
- Confirm that there are not multiple lines of data per provider organization per year, line of business, and attribution hierarchy in TME_PROV
- Confirm that data for all requested years are present in all appropriate tabs
    - Confirm that all expected lines of business have data in both TME_ALL and MARKET_ENROLL tabs.
- Confirm that all tabs are appropriately completed and tabs 1-9 are not left blank
    - Some tabs may be left blank for certain situations. For example, all members can be attributed to a primary care provider, there would be no data in the unattributed tab.
- OHA is interested in the attributed data by the provider organization, not at the individual provider level. Submitters must ‘roll up’ their data to the provider organization level.
- All rows of data in TME_ALL, TME_PROV, and TME_UNATTR must have a member month, demographic score, and demographic adjusted standard deviation PMPM (even if they are 0).
- Confirm use of the most recent data submission template
- Review the standard deviation for the TME_PROV and TME_UNATTR tabs. If the standard deviation is 0, check to see if there are no associated claims expenses or confirm with payer that all members in the row truly have the same PMPM.

If any of the preliminary checks listed above or any other large data quality issue are identified, OHA will initiate communication with the submitter. After discussion, the submitter may receive a Cost Growth Target Resubmission form explaining the potential issue(s) that requires resubmission. Once the issue(s) have been clarified or rectified, the data proceeds to Stage 1B.

1B

All unique providers listed in tab 3. TME_PROV are compared to all unique providers listed in Tab 9. PROV_ID. If there are any providers who do not have a corresponding entry in the other tab, they will be flagged for discussion with the submitter at the end of Stage 1.

OHA also checks whether all Provider Organization Name/IPA or Contract Name combinations that are in RX_MED_PROV are also in TME_PROV. Because RX_MED_PROV is a subset of TME_PROV, all providers in RX_MED_PROV should also be in TME_PROV.

Note that the provider names are free-text fields. OHA recognizes that there will be typos. These will be considered during the validation process and confirmed with the submitter and may not require a resubmission of the data.

1C

All unique combinations of the Year-LOB-Provider Organization Name-IPA or Contract Name-Attribution Hierarchy Code fields in RX_MED_PROV must be in TME_PROV, and all unique combinations of the Year-LOB field in RX_MED_UNATTR should be in TME_UNATTR. This is because the data in the medical pharmacy tabs should be a subset of the data in the total costs tabs.

1D

All related variables on tabs 2. TME_ALL, 3. TME_PROV and 4. TME_UNATTR will be analyzed. The weighted average of the demographic scores from tab 3. TME_PROV and tab 4. TME_UNATTR should be the same as the demographic score reported in tab 2. TME_ALL, by year and line of business. All other variables from tab 3. TME_PROV and tab 4. TME_UNATTR should sum to their counterpart on tab 2. TME_ALL. OHA will use the following formula:

TME_PROV variable + TME_UNATTR variable = TME_ALL variable

Member months will also be compared to the data in tab 5. MARKET_ENROLL. The member months in TME_PROV and TME_UNATTR should equal the member months in TME_ALL, by year and line of business. All member months in TME_ALL should equal all the member months in MARKET_ENROLL for the year of interest.

If any TME_PROV and TME_UNATTR variables do not accurately sum to their TME_ALL counterpart, then OHA will communicate with the submitter to regarding the potential issue at the end of Stage 1. Data continues to the end of Stage 1.

Stage 1 D also checks to see that the amounts listed in the RX_MED_PROV and RX_MED_UNATTR tabs are less than or equal to the corresponding amounts in TME_PROV and TME_UNATTR. For example, for Provider X in 2024, the total amount

spent on Hospital Inpatient Costs in Medicare Advantage at attribution tier 2 should not be higher in RX_MED_PROV than in TME_PROV.

Stage 1D also checks to see if the number of self-insured member months listed on the cover page tab match the number of self-insured member months in the market enrollment tab.

1E
Stage 1E checks for rows in TME_PROV with 12 or fewer member months. If only 12 or fewer member months can be attributed to a given provider organization, those member months should be included in the TME_UNATTR tab instead.

1F
Stage 1F performs three separate checks on the provider/TIN associations in TME_PROV.

The first (**Stage 1Fa**) generates a list of provider names in PROV_ID with more than one distinct TIN. In many cases, the provider names on this list may actually have more than one TIN that they bill under. However, examination of the specific provider names on this list may help OHA or the data submitter to identify cases where having a large number of TINS could be indicative of a data issue, for example when the provider listed is a small organization that typically bills under a single TIN.

The second check, **Stage 1Fb**, searches for TINs with more than one distinct provider name associated with them. Similar to stage 1Fa, there may be cases where the provider names/TINs flagged under this step are not problematic, such as when multiple distinct provider names are identified due to differences in spelling or punctuation. However, in cases where two seemingly distinct provider organizations are assigned to the same TIN, OHA may request additional information or a resubmission from the payer.

A final validation check, **Stage 1Fc**, checks for TINs with invalid values, including values of 999999999, 000000000 or TINs with fewer than nine digits.

End of Stage 1
If any issues are identified during Stage 1, OHA initiates communication with the submitter that the upcoming validation meeting will be focused on discussing data clarification points (Stage 1 checks). After discussion, the submitter may receive a Cost Growth Target Resubmission form explaining the potential issue(s) that require resubmission.

If the issue(s) have been clarified and data deemed acceptable, the data proceeds to Stage 2A. If the data needs to be rectified and resubmitted, the data restarts the validation process at Stage 1A.

Stage 2: Detailed Review

2A

OHA will analyze tab 2. TME_ALL data, by line of business, to assess any potential issues. Some of the analyses include, but are not limited to:

- PMPM and percent change in PMPM from year to year, for total TME by line of business, and broken out by service category
- Value of and change in demo scores and member months over the course of the two measurement years, by line of business

If any potential issues or questions are identified, then OHA will communicate with the submitter during Stage 3. Data continues to Stage 2B.

2B

OHA will analyze what percent of the member population in the TME_PROV tab is attributed at the different attribution tiers (member selection, contract arrangement, or utilization) in year 1 and year 2 of the measurement period, along with total claims and non-claims costs, PMPM, and demo score at each level. OHA will analyze these data by line of business and flag any questions or issues with the payer.

2C

OHA will analyze the tab 5. MARKET_ENROLL data to identify any potential issues. The percent change will be calculated to see if there were any large, unexplained variations in enrollment. Special considerations will be given to data due to the COVID-19 pandemic. If any potential issues are identified, then OHA will communicate with the submitter during Stage 3. Data continues to Stage 2D.

2D

OHA will analyze the tab 8. RX_REBATE data, by line of business, to identify any potential issues. Calculations include, but not limited to, comparing the pharmacy rebate to the total Claims: Retail Pharmacy by line of business. If any potential issues are identified, then OHA will communicate with the submitter during Stage 3. Data continues to Stage 3.

OHA will also analyze medical pharmacy data by line of business and claims category, calculating a PMPM for each year and comparing the growth in medical pharmacy PMPM from year 1 to year 2 of the period to the percent change in overall PMPM. OHA will also review what percent of the total PMPM overall and by claims category is made up of medical pharmacy costs in each year. Review of these data may help flag issues with the medical pharmacy submission.

2E

Stage 2E compares the Year 1 data submitted by the payer in the current data cycle to the data submitted for that same year in the previous data cycle (e.g., comparison of 2022 data submitted in 2023 for the 2021-2022 data cycle to 2022 data submitted in 2024 for the 2022-2023 data cycle). The output generated includes member months, demographic scores, and PMPM data in aggregate and at the service category level. Large differences in the figures submitted from the prior year may merit further discussion, to identify if they are the result of claims development in the intervening year, changes in payer methodology from year to year, or have other explanations.

2F

Stage 2F generates a list of the top ten provider organization names in the payer's data file by number of attributed member months and compares it to a parallel list generated using the payer's prior year data submission. This stage may help identify cases where the member months attributed to a given provider organization changed significantly between data submissions, which may be cause for further discussion and investigation.

2G

Stage 2G generates a list of provider organizations that were included in the CGT program in the previous measurement period and specifies the number of member months, PMPM, and average demographic score of the population attributed to those organizations across the two measurement years by line of business and attribution tier. The table also includes parallel data collected from the last data cycle for comparison. This stage may help identify cases where the attributed member months have changed significantly between data submissions and across years, which could indicate an issue or a methodology change that warrants further discussion between the data submitter and OHA.

Stage 3: Communication and Finalization

The submitted data will be discussed, including any issues identified during Stages 1 or 2 of the validation process. Documentation includes a list of discussion topics and the Stage 2 analytic outputs; these materials will be provided to the submitter via email and discussed during the Stage 3 one-on-one meetings between the submitter and OHA. OHA recommends that data submitters take time to digest the provided documentation before the meeting. This stage relies heavily on open communication between the submitter and OHA and each conversation will be unique to the submitter and their data.

If errors in the data have been identified, the submitter will receive a Cost Growth Target Data Clarification/Resubmission form that explains the issue that necessitates resubmission. The submitter must rectify the issues(s) and resubmit the data within 15 days of receiving the Resubmission form. Once OHA receives the updated submission, the validation process will begin again at Stage 1A.

Once all potential issues have been addressed and approved by OHA, then the data file is considered finalized and ready for statewide, market, payer, and provider organization analysis.

Data submitter role in provider data validation

Each year after all payer data is validated, OHA rolls up all data submissions and uses the information submitted in the PROV_ID and PROV_TME tabs to break TME data down at the provider organization level. Meetings are then held with provider organizations to validate that their data are correct.

In the process of meeting with provider organizations, additional issues potentially requiring a resubmission by the payer may be identified. Most often, these issues relate to provider organization attribution. As such, data submitters may expect to receive additional requests from OHA including but not limited to:

- **Requests to clarify provider organization/TIN associations:** In some cases, provider TINs become outdated and costs attributed to them may bear re-examination. In other cases, provider organizations may incorrectly attribute TINs to a given provider organization. Often, such situations are not identified until discussion with the provider organization, so data submitters may expect OHA to reach out for clarification after data summaries are shared with provider organizations.
- **Requests for lists of members attributed to a given provider organization:** To facilitate data validation at the provider level, OHA may facilitate exchange of data between payers and provider organizations on which specific members are attributed to a provider organization.
- **Requests to participate in meetings with provider organizations:** Other questions may arise in the process of provider data validation that require payer input. Data submitters should be ready to field such questions, particularly in regards to validating data for provider organizations that exceed the cost growth target.

Noncompliance

OHA provides data submitters multiple venues and resources for clarifying data submission requirements (Technical Advisory Group (TAG), data submission office hours leading up to data submission deadlines, 1:1 meetings with OHA, tailored feedback, etc.). The data validation process has also been designed to identify and correct errors in data submissions in a timely manner and to facilitate communication about and correction of any errors between OHA and mandatory data submitters.

CGT-1 data submitters are required to submit data that meets submission standards as outlined in this CGT-2 manual. Timely reporting of valid data also facilitates the Determining Reasonableness process for both payers and provider organizations. OHA reserves the right to issue a notice of noncompliance and intent to impose civil penalties to any data submitters who fail to submit or correct data, including required resubmissions.

As detailed in OAR 409-065-0025 Data Submission Compliance and Enforcement, OHA may issue a notice of noncompliance and intent to impose civil penalties if a mandatory reporter:

a. Submits a data file in an unapproved layout;
b. Submits a data element in an unapproved format;
c. Submits a data element with unapproved coding;
d. Fails to submit a required element; or
e. Fails to comply with validation and quality control efforts, including resubmitting or correcting data in a timely fashion as requested by OHA.

Once OHA issues a notice of noncompliance and intent to impose civil penalties, the data submitter must come into compliance within 30 calendar days. OHA has the authority to impose a civil penalty of up to $500 per day starting on the date of the notice of noncompliance, for each violation of items (a) and (b) above, and up to $400 per day starting on the data of the notice of noncompliance, for each violation of items (c) through (e) in the list above.

Data Submission Template

This section describes in detail each of the tabs in the Cost Growth Target Data Submission Template (CGT-1) and specifications for each field in the template.

The Template is organized into nine tabs:

1. Cover Page
2. Total Medical Expenses (TME) – All
3. Total Medical Expenses (TME) – Attributed to Provider Organizations
4. Total Medical Expenses (TME) – Unattributed
5. Market Enrollment Data
6. Medical Pharmacy Claims Expenses – Attributed to Provider Organizations
7. Medical Pharmacy Claims Expenses - Unattributed
8. Pharmacy Rebates Data
9. Provider Organization Identifiers

Data dictionaries for each tab are included in Appendix B.

Tab 1 – Cover Page

This tab includes payer's name and contact information, information about data completeness, and estimates applied to the data. Payers will also answer questions to confirm that their data submission follows the specifications and that are sound and correct. Payers should also provide attestation from an authorized signatory that the data submission is complete and accurate to the best of their knowledge. This attestation must be made each time a file is submitted or resubmitted.

This tab also includes space for payers with self-insured lines of business to provide total premiums received for self-insured accounts (in aggregate). This information is used to calculate the Net Cost of Private Health Insurance (NCPHI). Payers must follow the instructions from the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE), Part 1, Line 12, Income from Fees of Uninsured Plans.

Tabs 2-4 - Total Medical Expenses (TME)

Total Medical Expenses data are reported across three separate tabs. The definitions and instructions in this section apply to all three tabs.

#	Tab Name	Includes
2	TME_ALL– All	Total Medical Expenses for all of the payer's member months by line of business, regardless of attribution tier.
3	TME_PROV – Attributed to Provider Organizations	Total Medical Expenses for all of the payer's member months who are attributed to provider organizations (see Attribution section above). Data reported by line of business and by provider organization and attribution tier.
4	TME_UNATTR – Unattributed Members	Total Medical Expenses for all of the payer's member months who are not attributed to any provider organization. Data reported by line of business only.

Calculating TME

Total Medical Expenses (TME) includes all payments made to provider organizations by payers (both claims-based and non-claims-based). Claims-based payments are inclusive of patient cost sharing.

$$TME\ PMPM\ = \frac{Claims\ payments + Non\text{-}claims\ payments}{Attributed\ member\ months}$$

- TME should only be calculated for Oregon residents, regardless of whether services are provided by providers located in Oregon.
- Payers must calculate claims payments using allowed amounts (no truncation is applied to high-cost claims), which include payer payments to providers as well as patient liability for cost-sharing like co-payments, deductibles, co-insurance. However, when reporting coordination of benefit claims payment for **LOB code 5** (Medicare Expenses for Medicare/Medicaid Dual Eligible) and **LOB 6** (Medicaid Expenses for Medicare/Medicaid Dual Eligible) – these payments should be reported using **Paid Amounts** regardless of whether the payer is the primary or secondary payer.
- For reporting on LOB 1-4, payers must only report claims for members for which they are the primary payer on a claim; exclude any paid claim for which they are the secondary or tertiary payer, as this would result in double counting.
- Coordination of benefit claims should be included if the data submitter is the primary payer of those claims for members. Data submitters should exclude claims for members for which they are the secondary or tertiary payer.

- For reporting on LOB 5-6, payers must report all coordination of benefit claims for members; primary and secondary payers should report these costs using **Paid Amounts**. If a payer covers, and thus reports for, a dual eligible person's Medicare (LOB5) and Medicaid (LOB 6) expenses, that member's member months should be included in both rows of data.

- LOB 7 is reserved for CCO-F dental-only expenses, and for Medicaid Fee for Service Carve Out funds. CCOs and Medicaid FFS should only report LOB 7 in tab TME_ALL. LOB 7 includes CCO-F and Carve-Out spending for dual members (*Paid Amount* basis same as LOB 5 and 6).

The following expenses should NOT be included in TME calculations:

- Vision and dental expenses are generally excluded except where vision and dental services are covered as part of the medical benefit (see specific guidance for Medicaid CCOs above).
- Non-medical expenses are excluded, even if the expenses are made by a payer (e.g., gym memberships. See specific guidance for Medicaid CCOs above).
- Non-covered services are excluded (e.g., non-medical cosmetic surgery).

Line of Business

Payers will report TME data by line of business. There are seven lines of business for cost growth target reporting:

1. Medicare (excludes Dual Eligible)
2. Medicaid (excludes Dual Eligible)
3. Commercial: Full Claims
4. Commercial: Partial Claims
5. Medicare Expenses for Medicare/Medicaid Dual Eligible
6. Medicaid Expenses for Medicare/Medicaid Dual Eligible
7. CCO-F (specific to CCOs) and Medicaid Carve-Outs (specific to Medicaid FFS)

Members may change their lines of business from one to another during a calendar year. In this case, member months are allocated based on the number of months associated with each of the business lines, and their TME data are mutually exclusively allocated to each of the business lines based on the respective member months.

Data submitters should include all PEBB, OEBB, and FEHBP plans in the Commercial categories.

Commercial Full and Partial Claims

Commercial self-insured or fully-insured data for which the payer is able to collect information on all direct medical claims and any claims paid by a delegated entity should be reported in the “Commercial: Full Claims” category (LOB code 3).

Sometimes payers are only able to report claims payments for limited medical services due to benefit design, where some services such as behavioral health or pharmacy may be “carved out” or provided separately by other benefit providers. In these cases, payers should report this type of TME data separately as “Commercial: Partial Claims” (LOB code 4).

An adjustment should be made to any “partial claims” to allow for them to be comparable to full claims. The goal of the adjustment is to estimate what total expenses might be for those members without having to collect claims data from carve-out vendors, such as Pharmacy Benefit Managers or behavioral health vendors (see Vendors and Carved-Out Services under the How Spending is Categorized subsection for more details). Payers will need to share information about how they made these adjustments as part of the data submission in Tab 1 – Cover Page.

See the Which Lines of Business are Included? section for more detail about what payments (both received and expected) should be included.

Medicaid and Medicare Expenses for Dual Eligible

Payers should report medical expenses for dual eligible members (include full and partial members) using ***Paid Amounts*** because some dual spending would be omitted if using only Allowed Amounts. They should report these payments whether they are the primary or secondary payer for that member (i.e., report all coordination of benefit claims). Medicare-related expenses should be reported under LOB code 5 and Medicaid-related expenses should be reported under LOB code 6. For example, if a payer covers Medicare/Medicaid dual eligibles, but is only responsible for Medicaid services, expenditures for those dual eligibles are reported under LOB code 6. If a payer provides both Medicare and Medicaid benefits to dual eligibles, the payer should use both LOB codes 5 and 6, respectively, to report applicable expenditures.

Costs for Medicare/Medicaid dual eligible members should not be included in the Medicare or Medicaid LOB code 1 or 2.

Claims Payments by Service Category

In each of the TME tabs, payers must report claims payments by service category. Payers must report claims payments using the original allowed amounts (and paid amounts for LOB codes 5 and 6), not the demo-adjusted payments. No truncation is applied to high-cost claims.

To avoid double counting, all payment categories must be mutually exclusive. OHA may request additional information regarding how payers mapped their data into these categories to improve consistency in reporting across all payers.

Payers must report the following individual service categories:

Hospital Inpatient

This service category includes:

- All room and board and ancillary payments for all hospital types
- Both medical and behavioral hospitalizations
- Payments for emergency room services when the member is admitted to the hospital in accordance with the specific payer's payment rules

This service category does not include:

- Payments made for observation services
- Payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician
- Inpatient services at non-hospital facilities (e.g., residential treatment facilities)

Hospital Outpatient

This service category includes:

- All hospital types and payments made for hospital-licensed satellite clinics
- Emergency room services not resulting in admittance
- Observation services

This service category does not include:

- Payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician

Professional – Primary Care Providers

This service category includes claims paid to health care providers that are defined as a primary care provider (including, but not limited to: doctors of medicine or osteopathy in family medicine, internal medicine, general medicine, pediatric medicine, nurse practitioners, and physician assistants). See Appendix C for provider taxonomy codes.

Note that the primary care provider taxonomies used for this data submission template are based on the taxonomies used in the Primary Care Spending in Oregon Report. However, the Primary Care Spending in Oregon Report uses *both* the provider taxonomy and procedure code to identify a primary care service. Payers completing the CGT data submission template are not required to use procedure codes; however, payers have requested more guidance in identifying Professional: Primary Care

Providers using procedure codes. OHA has provided guidance in Appendix C: Provider Taxonomy.

Payers should utilize the taxonomy and, if they choose, optional procedure codes provided in Appendix C to identify primary care providers for this claims service category, or they may use their own internal methodology to match the description of the provider taxonomy codes provided.

Professional – Specialty Providers

This service category includes claims for services provided by doctors of medicine or osteopathy working in clinical areas other than family medicine, internal medicine, general medicine, or pediatric medicine, not defined as primary care (see above).

Professional – Behavioral Health Providers

This service category includes claims for services provided by behavioral health providers, including, but not limited to: physician - addiction specialist, physician – psychiatrist, community mental health center, certified community behavioral health clinic, counselor (including LMHC and LADC), early intervention agency, licensed social worker, local education agency, marriage and family therapist, peer recovery specialist, nurse practitioner (psychiatric), psychiatric rehabilitation practitioners, psychologist, registered behavior technician, and single specialty group. See Appendix C for provider taxonomy codes.

Payers completing the CGT data submission template are not required to use procedure codes; however, payers have requested more guidance in identifying Professional: Behavioral Health Providers using procedure codes. A supplemental procedure code list is also provided (Appendix C) to help payers identify behavioral health providers for this claims service category. Payers should utilize the taxonomy and, if they choose, optional procedure codes provided in Appendix C to identify primary care providers for this claims service category, or they may use their own internal methodology to match the description of the provider taxonomy codes provided.

Professional - Other Providers

This service category includes claims for services provided by licensed practitioners other than a physician, but not identified as primary care, specialist or behavioral health above. This includes, but is not limited to, licensed podiatrists, non-primary care nurse practitioners, non-primary care physician assistants, physical therapists, occupational therapists, speech therapists, dieticians, dentists, chiropractors and any other professional claims that do not fit other categories.

Long-Term Care

This service category includes claims for:

- Nursing homes and skilled nursing facilities (SNFs)

- Intermediate care facilities for individuals with intellectual disabilities (ICF/ID) and assisted living facilities
- Providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, eating, etc.), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with long-term care needs who receive care in their home and community, such as PACE and Money Follows the Person

This service category does not include:

- Payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner

Retail Pharmacy

This service category includes claims for prescription drugs, biological products, and vaccines as defined by the payer's prescription drug benefit. Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be included in the Hospital Inpatient service category).

Medicare Advantage insurers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their cost growth target data submission.

Pharmacy data should be reported gross of applicable rebates. See Pharmacy Rebates section below for additional detail.

Other

This service category includes claims for all other services not mentioned above, including, but not limited to:

- Durable medical equipment (DME)
- Freestanding diagnostic facility services
- Hospice
- Hearing aid services
- Optical services
- Transportation
- Facility fees for community health center services
- Facility fees for non-hospital owned ambulatory surgical center services

Payments for fitness club membership or membership discounts, whether given to the provider or given in the form of a capitated payment to an organization that assists the

insurer with enrolling members in the fitness club, should not be included in the cost growth target data submission. Guidance for Medicaid Coordinated Care Organizations regarding Health-Related Services and social determinants of health spending is provided in the section above.

Non-Claims Payments

Non-claims payments are all of the payments that payers make to providers outside of claims (as a TME component, like claims, this is spending as incurred by OR residents). If payers cannot split out non-claims payments for just OR residents, payers can use their own estimation to report these payments and summarize their methodology in Table 1.3 "Does TME data include Oregon residents only?" (for more estimation guidance see subsection Data Completeness).

Non-claims payments recorded in the TME_PROV and RX_MED_PROV tabs should be attributed in the same manner as claims payments; i.e., payers should make an attempt to assign these payments at the member level and then roll up all payments for a provider's attributed population and assign them to that provider. Any non-claims dollars that cannot be attributed accurately may be included in TME_UNATTR.

Payers must report the following individual non-claims payment categories:

Prospective Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments:

All non-claims based payments for services delivered under the following payment arrangements:

- Capitation payments, i.e., single payments to providers to provide healthcare services over a defined period of time;
- Global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a broadly defined population or a defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out;
- Case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time; and
- Prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.

Performance Payments:

All payments to reward providers for their performance based on specific metrics which could be related to quality of care, patient outcomes, or data reporting.

Includes pay-for-performance, i.e., payments to reward providers for achieving a set target, and pay-for-reporting, i.e., payments to providers for reporting on a set of metrics, usually to build capacity for pay-for-performance, payments. Does NOT include shared risk or shared savings disbursements.

If a payer has a vendor manage performance payments to providers on its behalf, these dollars should still be included in this category.

- If the payer has detailed data from the vendor about how much the performance payments made to providers were, allocate directly to the provider organizations.
- If the payer does not have data from the vendor about performance payments, follow the guidelines for administrative costs and reasonable estimates in the Data Completeness section above.

In the case that a payer is unable to separate out performance payments from shared savings and shared risk settlements (see the next section), the payer should report these payments in the category that they believe best represents the majority of their metrics-based performance payments.

Shared Savings and Shared Risk Settlements:

All payments made as a part of financial arrangements where providers are rewarded for achieving cost savings and/or quality goals for a defined set of services over a specific period. Providers may share in the savings generated or bear financial risk if costs exceeded expectations. Includes shared savings and shared risk settlements for fee-for-service episode-based contracts and fee-for-service total cost of care contracts.

Payments to Support Population Health and Practice Infrastructure:

All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population; data analytics; EHR/HIT infrastructure payments; medication reconciliation; patient-centered medical home (PCMH) recognition payments and primary care and behavioral health integration *that are not reimbursable through claims*.

Health-Related Social Needs (HRSN) Payments:

This category is for use by CCOs that have made non-claims payments for health-related social needs (HRSN). For the 2023-2024 submission period, claims payments for HRSN can also be included in this category. HRSN payments should not be attributed to provider organizations, even if they can be associated with a member that is attributed to a provider. Only include them in the TME_ALL and TME_UNATTR tabs.

Recovery:

All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation.

This should NOT include recoveries processed through the claims system; these recoveries should be netted out of their respective claims categories. This category also excludes settlements, including repayments from providers, made as a part of value-based payment arrangements (e.g., shared risk settlements). Those payments should be included under Shared Savings and Shared Risk Settlements.

This field should be reported as a **negative number**. Only report data in this category not otherwise included elsewhere.

Other:

All other payments made pursuant to the payer's contract with a provider not made on the basis of a claim for healthcare benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. This category also includes payments for provider salaries (which was a separate category through the 2024 data submission).

Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Standard Deviation

In October 2020, the Implementation Committee recommended a tiered approach to accountability, including reporting of performance, based on statistical confidence. This approach should determine when a payer or provider organization would be held accountable for performance against the cost growth target over one or more years. Testing for statistical confidence is a foundational step before any accountability mechanisms would apply. A full description of OHA's statistical methodology is available online at: https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

For OHA to conduct the statistical confidence calculations, payers will need to report information about the distribution of costs associated with their enrollees.

Calculating Standard Deviation Values for the Data Submission

Data submitters must provide the standard deviation so that the OHA team can calculate the confidence intervals for year-to-year cost growth. See the Supplemental SD Calculation Excel spreadsheet posted online for examples and calculations.

Step 1

Attribute members to the appropriate provider organization. (See Attribution under the Additional Details subsection for how to perform the attribution).

Note that it is possible that a member is attributed to multiple provider organizations during a single year, but never at the same time. For example, a member could be attributed to one provider organization from January to July, and a different provider organization from August to December.

Step 2

For each line of business, for each provider organization, and for each attribution hierarchy, the data submitter must calculate the average per month amount for each member using claims-based allowed amounts. This is done for *all* members attributed to that provider entity, or in the case of the unattributed cohort, *all* unattributed members. The standard deviation reflects the distribution of costs regardless of utilization. For partial claims rows (Line of Business 4), payers should calculate the standard deviation PMPM *after* partial claims adjustment.

Next, the data submitter should apply any demo-adjustment to the average per month expenditure value based on the age-sex of that member.

Note that non-claims expenditures, such as quality incentive bonus payments, shared savings or risk payments, and any capitation payments should be ***excluded*** from this average. The reason for excluding these payments is because they do not affect the standard deviation when proportionally attributing these costs to the members. Therefore, these costs are excluded from the calculation of standard deviation. Note, however, that non-claims spending is included when calculating cost growth.

Step 3

Use the demo-adjusted per month average for each individual and multiply that value by the number of enrolled months for that member. Sum the values for all members and divide by the total number of member months to produce a demo-adjusted per member per month dollar amount that is specific to a given line of business, provider organization, and attribution hierarchy.

Note that when calculating the standard deviation of the population for the Cost Growth Target Program, data submitters must use each member's average cost applied to each month they were enrolled, instead of the actual utilization each month.

For example, Member 1 is assigned to Hospital System Z via the Tier 1 attribution and was enrolled for four months from September to December. Member 1's average unadjusted claims expenses is $225, which is the result of dividing $900 by 4. Apply the member's demographic factor, 1.29, to get the demo-adjusted per month average for that member, $174.42.

Unadjusted:

Month	Allowed amount
Sep	$200
Oct	$400
Nov	$0
Dec	$300
Total	**$900**
Per Month	**$225**

For calculating the standard deviation of Hospital System Z's Tier 1 attributed population, we use the $174.42 demo-adjusted value and include the number of months the member was enrolled.

The Sustainable Health Care Cost Growth Target Program is not focused on how a given member's utilization changes from month to month; rather, the program focuses on overall cost growth using a basis of attributed members and the provider organizations to which they are attributed.

Step 4

With the average demo-adjusted claims expenses value for each provider organization, data submitters can now calculate the standard deviation. The formula is:

$$SD = \sqrt{\frac{\sum_i (X_i - \bar{X})^2}{N}}$$

Using the Excel function STDEV.P() or other standard deviation commands in any other statistical software program, data submitters can calculate the demo-adjusted standard deviation of the PMPM costs for a given line of business, provider organization, and attribution hierarchy.

Note that when calculating standard deviation, data submitters should use the formula for *population* standard deviation (divided by N). Data submitters should NOT use the formula for *sample* standard deviation (divided by N-1).

Step 5

Report the standard deviation values for attributed member months in the Data Submission Template (CGT-1) on Tab 3 for each row. Report the standard deviation values for unattributed member months in the Data Submission Template (CGT-1) on Tab 4.

Tab 5 - Market Enrollment

This tab includes payer's member months by market enrollment category. Member Months (annual) are the number of unique members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy.

Member months should be reported across the following market enrollment categories:

1. Large group fully insured (51 + employees)
2. Small group fully insured (2 – 50 employees)
3. Self-insured
4. Individual (buy coverage on their own)
5. Student plans
6. Medicare Advantage
7. Medicaid Managed Care
8. Medicare Medicaid duals

Payers should not include Medigap members but should include D-SNP members.

Tabs 6-7 – Medical Pharmacy Claims

Beginning with the 2024 data submission cycle, OHA requires payers to provide an additional breakout of total medical expenses for medical pharmacy claims, to allow the State, payers, and provider organizations to track what proportion of spending is going to drugs administered or provided in a clinical setting. This metric will include claims payments made for drugs, excluding the cost of drug administration and associated supplies.

Data submitters can identify costs for drugs administered in a medical setting by filtering their medical claims for claim lines that meet any of the following criteria:

- Any lines that have a valid/non-null National Drug Code (NDC) value on them should be included, if that is a field available in the data submitter's system; or
- Any lines with a CPT/HCPCS code that matches the list provided by OHA as a supplement to the data manual (Appendix E, a CSV file available on the data submission website; see note); or
- Any lines with a revenue code of 025x, 063x, 086x, 0343,0344, 0262, or 0547 that also have a null CPT/HCPCS code.

Note that a given claim line may meet any of the criteria described above, or a combination of the criteria (e.g., lines may have both a relevant revenue code and an NDC). All lines meeting any of the above criteria alone or in combination should be included for the purposes of calculating the total amount of spending on drugs in a medical setting billed through medical claims.

Medical pharmacy costs should be classified using the same sub-categories as other claims member months and expenditures such as Hospital Inpatient; Hospital Outpatient, etc.

Medical pharmacy claims totals should be entered in Tabs 6-7. Tab 6 includes costs broken out by provider organization where possible, and Tab 7 contains unattributed medical pharmacy costs. All claims expenses entered in Tabs 6-7 should also be included in Tab 3 TME_PROV and Tab 4 TME_UNATTR – i.e., Tabs 6-7 and 3-4 are not mutually exclusive. Each claims subcategory/column in Tabs 3-4 should be fully representative of all claims in each of the subcategory, while the data in Tabs 6-7 will be used to examine medical pharmacy costs and cost growth in more detail.

[Note: This list was constructed by combining CPT/HCPCS codes for medical pharmacy in Average Sales Price (ASP) files from CMS; separately payable drugs listed in OPPS Addendum B; and codes in the HCPCS/NDC crosswalk maintained by Medicare's Contractor for Pricing, Data Analysis and Coding. OHA will update its list of medical pharmacy codes on an annual basis as updates become available.]

Tab 8 - Pharmacy Rebates

The pharmacy rebates data are the source of the payers' pharmacy rebates at state, market, payer, and sometimes, provider entity levels. Payers are required to report the pharmacy rebates data by year, line of business, and optionally by provider organization. Payers should not try to allocate pharmacy rebates at the member level. *To avoid double counting, all payment rows must be mutually exclusive*, see example below:

Pharmacy rebate reporting example

In 2024, Payer A has a total pharmacy rebate amount of $1,000,000 for LOB 3. They cannot separate this out into Medical (RXR03) and Retail (RXR04) amounts and are using the optional Total field (RXR05).

If Payer A can attribute $300,000 to Provider Organization 1, they could enter these numbers in Tab 8. RX_REBATE as so:

Reporting Year	Line of Business Code	Provider Organization Name (Optional)	Total Pharmacy Rebate Amount (Optional)
2024	3		-$700,000
2024	3	Provider Organization 1	-$300,000

The reporting example below is also correct:

Reporting Year	Line of Business Code	Provider Organization Name (Optional)	Total Pharmacy Rebate Amount (Optional)
2021	3		-$1,000,000

Total rebates should be reported without regard to how they are paid to the payer (e.g., through regular aggregate payments, on a claim-by-claim basis, etc.). Pharmacy rebates should be reported as a negative number.

Note that for Medicaid, OHA will be reporting pharmacy rebates that it captures for the Oregon Health Plan and will apply these rebates at the Medicaid market level. OHA does not intend to report pharmacy rebates for the Oregon Health Plan at the CCO level.

Retail Pharmacy and Medical Pharmacy Rebates

Payers should report both retail pharmacy rebates and medical pharmacy rebates.

Retail Pharmacy

Pharmacy rebates for retail pharmacy are reported as the estimated value of rebates attributed to Oregon residents provided by pharmaceutical manufactures for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair market value bona fide service fees[5] for retail prescription drugs.

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

Medical Pharmacy:

Pharmacy rebates for medical pharmacy are reported as the estimated value of rebates attributed to Oregon residents provided by pharmaceutical manufactures for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair market value bona fide service fees for pharmaceuticals that are paid for under the member's medical benefit. These drugs may be included in the professional claims category with J codes or part of facility fees for drug infusions administered in the outpatient setting.

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

If data submitters are unable to separate out retail and medical pharmacy rebates for reporting, all pharmacy rebates should be reported in aggregate in the optional field RXR05 in Tab 8 of the Data Submission Template.

Estimating Pharmacy Rebates

Pharmacy rebates may have long tails (e.g., 12 or more months) and payers may not have complete pharmacy rebate data for a measurement period in time for the annual cost growth target data submission.

Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the reporting period.

[5] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurance carriers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

If payers are unable to report rebates specifically for Oregon residents, payers should report estimated rebates attributed to Oregon residents in a proportion equal to the proportion of pharmacy spending for Oregon residents compared to pharmacy spending for total members, by line of business. For example, if Oregon commercial member spending represents 10% of a payer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported.

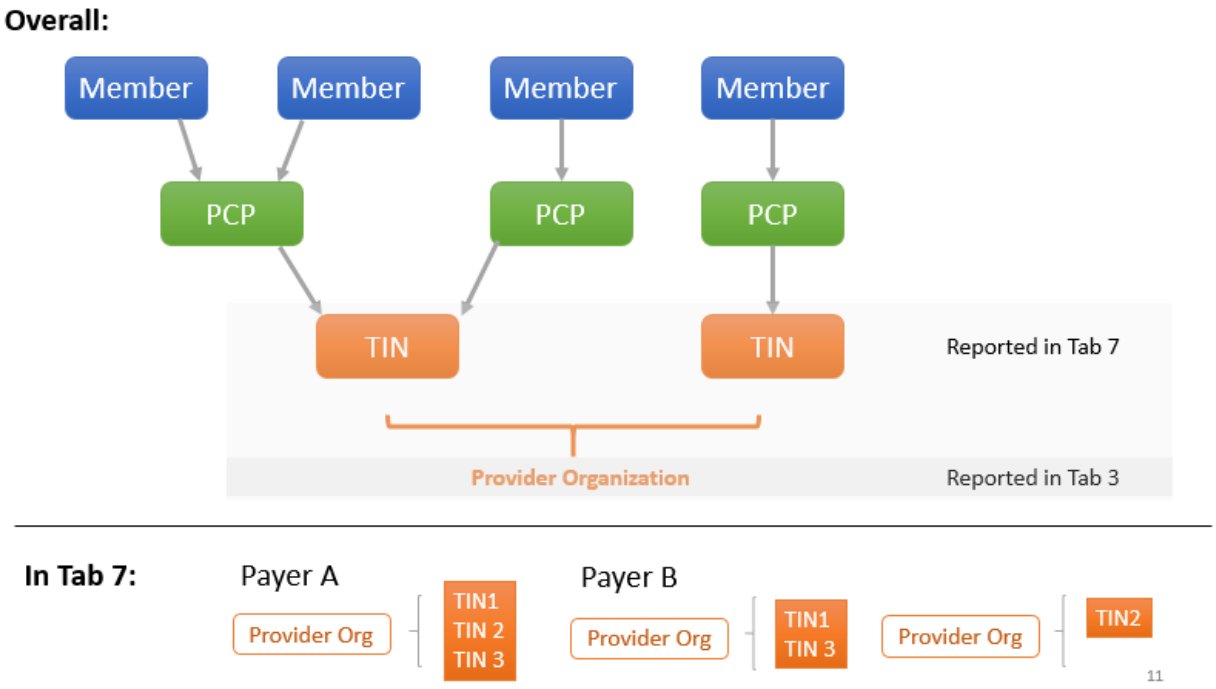
If payers are unable to identify the percentage of pharmacy spending for Oregon residents, then the payer should calculate the pharmacy rebates attributable to Oregon residents using percentage of membership.

Pharmacy Rebates Passed Back to Employers

Some self-funded employer groups ask for portions of the rebates to be passed along to them. Payers should report any rebates they receive, regardless of whether they are passed along to employers.

Tab 9 – Provider Organization Information

To assist with matching provider organizations across multiple payer data submissions, Tab 9 collects multiple identifiers for provider organizations. Payers should complete this table with the associated taxpayer identification numbers (TINs) that they have for a provider organization. Payers should enter multiple associated TINs for a provider organization, if available. See below for a diagram of how this information should be organized across Tab 3 and Tab 9.



This information will be used to construct a more precise list of provider organizations for inclusion in the Cost Growth Target Program in future years.

Appendix A: Version History

Version number	Date released	Description of change(s)
5.0	June 11, 2025	• Clarified that cost growth by market at the statewide level is reported on a per capita, not PMPM basis in OHA's annual Health Care Cost Trends report, and added Other spending to definition of THCE. • Clarified treatment of member residency for student health plans • Clarified what attribution tier to use for lines with both a provider organization name and IPA or Contract name. • Added requirement to fill out the IPA or Contract name field for cases where members can be attributed at both levels. • Updated and reorganized section on member attribution. • Clarified what value to enter in the Provider Organization TIN field if costs can only be attributed at the IPA or Contract level. • Updated provider taxonomy table to clarify that physician assistant taxonomies also refer to physician associates in Oregon per HB 4010 (2024). • Added language to underline that non-claims payments made as a reward for provider performance should be assigned to year during which the performance was tracked. • Added three new non-claims categories (Performance Payments; Shared Savings and Shared Risk Settlements; Payments for Health-Related Social Needs (HRSN) by CCOs) and removed two non-claims categories (Performance Incentive Payments and Provider Salaries). Added language to clarify that costs previously reported under the Provider Salaries category should reported under Non-Claims Other. • Added specification that HRSN costs are only included in the TME_UNATTR and TME_ALL tabs. • Updated Data Submission Schedule with submission date for 2027 and removed 2024 data submission information. • Added language to underline that payers should have an authorized signer certify the submission each time a submission or resubmission is made. • Added language describing new validation checks for medical pharmacy and provider attribution that will be carried out by OHA each year. Updated descriptions of each validation stage. • Added language describing medical pharmacy validation checks added to the CGT-1 data submission template. • Added CCO-F and Medicaid Open Card Carve-Outs LOB 7 to the list of Lines of Business • Updated list of medical pharmacy CPT/HCPCS codes. • Added description of the notice of non-compliance with rules for data submission. • Added language to emphasize that payers should attribute non-claims dollars at the member level before rolling up to a provider organization.

Appendix B: Data Dictionary

Tab 1. Cover Page

Table #	Data Element Name	Type	Description
	Payer Name	Text	Name of the payer
	Contact Name	Text	Name of the contact person
	Contact Email	Text	Email address of the contact person
1.1	What is the overall completeness of the claims data (please reported as %)?	Percentage	The overall completeness of the claims data that the payer reported in TME tabs. If completeness of the claims data drops below a given threshold (98%), OHA reserves the right to request payers to calculate IBNR and/or provide supplemental information.
1.1	How long was the claims runout period for claims payments? (please report as days)	Integer	The runout period for the claims payments that the payer reported in TME tabs. Payers shall allow for a run-out period of at least 180 days after December 31 of the measurement year. i.e., payers should not pull the data until after June 30 of the year following the measurement year.
1.1	How long was the runout period for non-claims payments? (please report as days)	Integer	The runout period for the non-claims payments that the payer reported in TME tabs. Payers shall allow for a run-out period of at least 180 days after December 31 of the measurement year. i.e., payers should not pull the data until after June 30 of the year following the measurement year.
1.1	Are claims reported without IBNR/IBNP factors applied? If no, please explain why in the Comments field.	Drop-down list	Confirm that IBNR/IBNP are not applied to claims payments.
1.1	Is pharmacy rebate data estimated? If yes, how?	Drop-down list	Confirm that whether the pharmacy rebate data is estimated or not. If yes, please describe the method in comment field.

Table #	Data Element Name	Type	Description
1.1	What carve-out services are estimated?	Text	For commercial: partial claims only. Specify what carve-out services are estimated in the data reported in the data submission template.
1.1	Does each of the provider organizations reported in Tab 3 have at least one TIN reported in Tab 9?	Drop-down list	Confirm that all provider organizations listed in Tab 3 have at least one federal taxpayer ID number listed in Tab 9.
1.2	For lines of business = 1, 2, 3, or 4, are the claims payments reported as allowed amounts, including both payments that payers paid to providers and member cost sharing? If no, please explain why in the Comments field.	Drop-down list	Confirm that the claims payments are reported using allowed amounts, which includes payments that payers paid to providers and member cost sharing.
1.2	For lines of business = 5 or 6, are the claims payments reported as paid amounts, including only the payments that payers paid to providers? If no, please explain why in the Comments field.	Drop-down list	Confirm that the claims payments reported for LOBs 5 and 6 are using paid amounts.

Table #	Data Element Name	Type	Description
1.2	Are the payments reported in a manner consistent with the service category definitions outlined in the Data Specification Manual?	Drop-down list	Confirm that the spending reported in the Data Submission Template (CGT-1) is consistent with the service category definitions outlined in the Data Specification Manual (CGT-2).
1.2	Does the TME data include Oregon residents only?	Drop-down list	Confirm that the data reported in the Data Submission Template (CGT-1) only includes Oregon residents. Confirm that out-of-state residents who receive care from Oregon providers are not included.
1.2	Does the TME include services provided by providers, regardless of location of provider?	Drop-down list	Confirm that the data in the Data Submission Template (CGT-1) includes all the providers providing care to Oregon residents, no matter the services are provided by the providers in or outside of Oregon.
1.2	Does the TME include services provided by providers, regardless of the situs of the member's plan?	Drop-down list	Confirm that the data reported the Data Submission Template (CGT-1) includes all the providers providing care to Oregon residents, no matter the situs of the member’s plan.
1.2	For LOB 1-4, are the data limited only to members for whom the insurer is primary on the claim?	Drop-down list	Confirm that the reported members are limited only to members for whom the payer is the primary payer.
1.2	For LOB 5-6, are the data reported for all members regardless of whether the insurer is primary on the claim?	Drop-down list	Confirm that the reported members are NOT limited only to members for whom the payer is the primary payer.

Table #	Data Element Name	Type	Description
1.2	Are members attributed to provider organizations consistent with each contract?	Drop-down list	Confirm that members attributed to provider organizations reported in tab TME-PROV are consistent with the contracts.
1.2	Are TME data submitted based on the incurred date/date of service?	Drop-down list	Confirm that TME data reported in the data submission template is based on the date of service, not the paid or reconciled date.
1.2	Please describe (briefly) the method you used to attribute patients to provider organizations under attribution tier 3 (utilization), if a level 3 attribution was used. Please include the length of any claims look-back periods applied as a part of the methodology and how many claims a patient had to have with a PCP to be attributed to them.	Text	Summarize the attribution logic for members attributed to provider entities using tier 3.
1.2	Please describe any major changes in your methodology for this year's data submission relative to prior years that could impact your member months, demographic	Text	Describe any substantial changes in payer submission methodology that could affect the member months, demographic scores, or PMPMs of this file compared to the previous year’s file.

Table #	Data Element Name	Type	Description
	scores or PMPMs in this year's data, or that could impact these measures for provider organizations with attributed data.		
1.3	Are the standard deviations calculated using the formula for *population* standard deviation?	Drop-down list	Confirm that the standard deviations reported in the data submission template are calculated using the formula for population standard deviation. See Standard Deviation for additional details.
1.3	Are non-claims expenses excluded from calculating standard deviations?	Drop-down list	Confirm that non-claims are excluded when calculating standard deviations. See Standard Deviation for additional details.
1.3	When calculating the standard deviation, do you include all the member months, regardless of whether the member has paid claims for that month?	Drop-down list	Confirm that when calculating the standard deviation, all the member months are included regardless of whether the member has paid claims for that month. See Standard Deviation for additional details.
1.3	When calculating the standard deviation, do you use each member's average cost per month applied to each month they were enrolled, instead of the actual utilization each month?	Drop-down list	Confirm that when calculating the standard deviation, payers use each member's average cost per month applied to each month they were enrolled. Confirm that payers did not use actual utilization of each month to calculate standard deviation. See Standard Deviation for additional details.
1.3	When calculating the standard	Drop-down list	Confirm that when calculating standard deviation, payers use demographic-

Table #	Data Element Name	Type	Description
	deviation, do you use demo-adjusted member's average cost per month?		adjusted member's average cost per month. See Standard Deviation for additional details.
1.4	Do you have self-insured lines of business reported in Tab 5. MARKET_ENROLL ?	Drop-down list	Yes/No. Should align with information reported in Tab 5. Respond for each year.
1.4	If yes, please enter the income from fees of self-insured plans here.	Text	Enter Income from Fees of Uninsured Plans, NAIC SHCE Part 1, Line 12

Tab 2. TME_ALL – All Spending (TME_PROV & TME_UNATTR)

Data Element	Name	Type	Description
TMEALL01	Reporting Year	Year	Year for which data is being reported.
TMEALL02	Line of Business Code	Integer, from 1 to 7	This field indicates the line of business being reported. 1 = Medicare (Exclude Dual Eligible) 2 = Medicaid (Exclude Dual Eligible) 3 = Commercial: Full Claims 4 = Commercial: Partial Claims 5 = Medicare Expenses for Medicare/Medicaid Dual Eligible 6 = Medicaid Expenses for Medicare/Medicaid Dual Eligible See Line of Business for additional details. 7 = CCO-F (CCOs only) or Medicaid Carve-Outs (Medicaid FFS only)
TMEALL03	Member Months	Positive integer	The number of members enrolled in a plan over the reporting calendar year expressed in months of membership. **Note that if the number of member months is fractional, round it to the nearest integer.**
TMEALL04	Demographic Score	Positive Number	The weighted average demographic adjustment factor for the member population. See Demographic Adjustment for additional details.
TMEALL05	Claims: Hospital Inpatient	Number, no negative value	Sum of the allowed amount from the claims for hospital inpatient services. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEALL06	Claims: Hospital Outpatient	Number, no negative value	Sum of the allowed amount from the claims for hospital outpatient services. See Claims Payments by Service Category for additional

Data Element	Name	Type	Description
			details. **Note that this allowed amount is not demo-adjusted.**
TMEALL07	Claims: Professional, Primary Care Providers	Number, no negative value	Sum of the allowed amount from the claims for physicians or physician group practices that defined as a PCP. OB/GYNs are not considered a PCP for this purpose. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEALL08	Claims: Professional, Specialty Providers	Number, no negative value	Sum of the allowed amount from the claims for physicians or physician group practices that are NOT defined as a PCP. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEALL09	Claims: Professional, Behavior Health Providers	Number, no negative value	Sum of the allowed amount from the claims for providers that are defined as behavior health providers. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEALL10	Claims: Professional, Other Providers	Number, no negative value	Sum of the allowed amount from the claims for health care providers for services provided by a licensed practitioner other than a physician, a physician group, or identified as a PCP. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEALL11	Claims: Long-Term Care	Number, no negative value	Sum of the allowed amount from the claims for long-term care services. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**

Data Element	Name	Type	Description
TMEALL12	Claims: Retail Pharmacy	Number, no negative value	Sum of the allowed amount from the claims for the retail pharmacy services. This should not include claims paid for pharmaceuticals under the insurer's medical benefit. See Claims Payments by Service Category for additional details. **Note that allowed amount is not demo-adjusted.**
TMEALL13	Claims: Other	Number, no negative value	Sum of the allowed amount from the claims for all other services not mentioned above. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEALL14	Non-Claims: Prospective Payments	Number, no negative value	Sum of all the non-claims payments from the payer to providers for prospective capitated, prospective global budget, prospective case rate, or prospective episode-based payments. See Non-Claims Payments for additional details.
TMEALL15	Non-Claims: Performance Payments	Number, no negative value	Sum of the non-claims payments from the payer to providers for performance payments. This includes pay-for-performance and pay-for-reporting. See Non-Claims Payments for additional details.
TMEALL16	Non-Claims: Shared Savings and Shared Risk Settlements	Number	Sum of the non-claims payments from the payer to providers for shared risk and shared savings settlements. Note that shared risk recoupments are reported as a negative number, but all other incentive payments that payers pay to providers are positive numbers. This field is the net amount and could be either positive or negative. See Non-Claims Payments for additional details.

Data Element	Name	Type	Description
TMEALL17	Non-Claims: Payments to Support Population Health and Practice Infrastructure	Number, no negative value	Sum of the non-claims payments from the payer to providers to support population health and practice infrastructure. See Non-Claims Payments for additional details.
TMEALL26	Non-Claims: HSRN	Number, no negative value	Payments made by CCOs for Health-Related Social Needs of their members. See Non-Claims Payments for additional details.
TMEALL18	Non-Claims: Recovery	Number, no positive value	Sum of the non-claims payments from a provider, member/beneficiary or other payer because of a review, audit, or investigation. This field should be reported as a **negative number**. See Non-Claims Payments for additional details.
TMEALL19	Non-Claims: Other	Number, no negative value	Sum of the non-claims payments from the payer to providers that cannot be properly classified elsewhere. See Non-Claims Payments for additional details.
TMEALL20	Total Claims Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the allowed amount of claims payments. This is calculated by summing from TMEALL05 to TMEALL13. Payers should review this field for reasonableness.
TMEALL21	Total Non-Claims Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the non-claims payments from the payer to providers. This is calculated by summing from TMEALL14 to TMEALL19. Payers should review this field for reasonableness.
TMEALL22	Unadjusted Total Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the non-adjusted allowed amount of claims and all the non-claims expenses from the payer to

Data Element	Name	Type	Description
			providers. This is the sum of TMEALL20 and TMEALL21.
TMEALL23	Unadjusted TME PMPM	Number, no payer data entry needed	**This field is calculated.** It is to display the TME per member per month before demographic adjustment. This is calculated by dividing TMEALL22 by TMEALL03.
TMEALL24	Demographic Adjusted Total Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the demo-adjusted allowed amounts of claims and all the non-claims payments from the payer to providers. This is calculated by dividing TMEALL20 by TMEALL04 and then adding it to TMEALL21.
TMEALL25	Demographic Adjusted TME PMPM	Number, no payer data entry needed	**This field is calculated.** It is to display demo-adjusted TME per member per month. This is calculated by dividing TMEALL24 by TMEALL03.

Tab 3. TME_PROV – Members Attributed to Provider Organizations

Data Element	Name	Type	Description
TMEPRV01	Reporting Year	Year	Year for which data is being reported.
TMEPRV02	Line of Business Code	Integer, from 1 to 6	This field indicates the line of business being reported. 1 = Medicare (Exclude Dual Eligible) 2 = Medicaid (Exclude Dual Eligible) 3 = Commercial: Full Claims 4 = Commercial: Partial Claims 5 = Medicare Expenses for Medicare/Medicaid Dual Eligible 6 = Medicaid Expenses for Medicare/Medicaid Dual Eligible See Line of Business for additional details.
TMEPRV03	Provider Organization Name	Text	Indicates the full name of the provider organization that the members are attributed to. **This field cannot be blank.**
TMEPRV04	IPA or Contract Name	Text, blank is allowed	This is a required field to indicate the name of the IPA or contract group a member is included in (if applicable).
TMEPRV06	Attribution Hierarchy Code	Integer, From 1 to 3	This field indicates how the members are attributed to the provider organization. 1 = Tier 1 Member Selection 2 = Tier 2 Contract Arrangement 3 = Tier 3 Utilization See Attribution for additional details.
TMEPRV07	Member Months	Positive integer	The number of members enrolled in a plan over the reporting calendar year expressed in months of membership. **Note that**

Data Element	Name	Type	Description
			if the number of member months is fractional, round it to the nearest integer.
TMEPRV08	Demographic Score	Positive number	The weighted average demographic adjustment factor for the member population. See Demographic Adjustment for additional details.
TMEPRV09	Claims: Hospital Inpatient	Number, no negative value	Sum of the allowed amount from the claims for hospital inpatient services. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV10	Claims: Hospital Outpatient	Number, no negative value	Sum of the allowed amount from the claims for hospital outpatient services. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV11	Claims: Professional, Primary Care Providers	Number, no negative value	Sum of the allowed amount from the claims for physicians or physician group practices that defined as a PCP. OB/GYNs are not considered a PCP for this purpose. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV12	Claims: Professional, Specialty Providers	Number, no negative value	Sum of the allowed amount from the claims for physicians or physician group practices that are NOT defined as a PCP. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV13	Claims: Professional, Behavior Health Providers	Number, no negative value	Sum of the allowed amount from the claims for providers that are defined as behavior health providers. See Claims Payments

Data Element	Name	Type	Description
			by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV14	Claims: Professional, Other Providers	Number, no negative value	Sum of the allowed amount from the claims for health care providers for services provided by a licensed practitioner other than a physician, a physician group, or identified as a PCP. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV15	Claims: Long-Term Care	Number, no negative value	Sum of the allowed amount from the claims for long-term care services. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV16	Claims: Retail Pharmacy	Number, no negative value	Sum of the allowed amount from the claims for the retail pharmacy services. This should not include claims paid for pharmaceuticals under the insurer's medical benefit. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV17	Claims: Other	Number, no negative value	Sum of the allowed amount from the claims for all other services not mentioned above. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEPRV18	Non-Claims: Prospective Payments	Number, no negative value	Sum of all the non-claims payments from the payer to providers for prospective capitated, prospective global budget, prospective case rate, or prospective episode-based

Data Element	Name	Type	Description
			payments. See Non-Claims Payments for additional details.
TMEPRV19	Non-Claims: Performance Payments	Number, no negative value	Sum of the non-claims payments from the payer to providers for performance payments. This includes pay-for-performance and pay-for-reporting. See Non-Claims Payments for additional details.
TMEPRV20	Non-Claims: Shared Risk and Shared Savings Settlements	Number	Sum of the non-claims payments from the payer to providers for shared risk and shared savings settlements. Note that shared risk recoupments are reported as a negative number, but all other incentive payments that payers pay to providers are positive numbers. This field is the net amount and could be either positive or negative. See Non-Claims Payments for additional details.
TMEPRV21	Non-Claims: Payments to Support Population Health and Practice Infrastructure	Number, no negative value	Sum of the non-claims payments from the payer to providers to support population health and practice infrastructure. See Non-Claims Payments for additional details.
TMEPRV22	Non-Claims: Recovery	Number, no positive value	Sum of the non-claims payments from a provider, member/beneficiary or other payer because of a review, audit, or investigation. This field should be reported as a **negative number**. See Non-Claims Payments for additional details.
TMEPRV23	Non-Claims: Other	Number,	Sum of the non-claims payments from the payer to providers that cannot be properly classified

Data Element	Name	Type	Description
		no negative value	elsewhere. See Non-Claims Payments for additional details.
TMEPRV24	Demographic Adjusted Standard Deviation PMPM	Number, no negative value	The standard deviation of demo-adjusted TME PMPM. Although payers report unadjusted claims payments, payers must report the demo-adjusted standard deviation of TME PMPM. ***N*** **is the number of member months by attribution hierarchy, by provider organization and by line of business.**
TMEPRV25	Total Claims Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the allowed amount of claims payments. This is calculated by summing from TMEPRV09 to TMEPRV17. Payers should review for reasonableness.
TMEPRV26	Total Non-Claims Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the non-claims payments from the payer to providers. This is calculated by summing from TMEPRV18 to TMEPRV23. Payers should review this field for reasonableness.
TMEPRV27	Unadjusted Total Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the non-adjusted allowed amount of claims and all the non-claims payments from the payer to providers. This is the sum of TMEPRV25 and TMEPRV26.
TMEPRV28	Unadjusted TME PMPM	Number, no payer data entry needed	**This field is calculated.** It is to display the TME per member per month before demo adjustment. This is calculated by dividing TMEPRV27 by TMEPRV07.
TMEPRV29	Demographic Adjusted Total Expenses	Number,	**This field is calculated.** It is to display all the demo-adjusted allowed amounts of claims and all

Data Element	Name	Type	Description
		no payer data entry needed	the non-claims payments from the payer to providers. This is calculated by dividing TMEPRV25 by TMEPRV08 and then adding it to TMEPRV26.
TMEPRV30	Demographic Adjusted TME PMPM	Number, no payer data entry needed	**This field is calculated.** It is to display demo-adjusted TME per member per month. This is calculated by dividing TMEPRV29 by TMEPRV07.
TMEPRV31	Unique combination check	Text, no payer data entry needed	**This field is calculated.** It is to identify duplicate entries at the Year-LOB-Provider Name-IPA/Contract Name – Attribution Hierarchy Code level. All costs should be rolled up at this level so data submitters should identify any rows that say “Duplicate Row” and roll all costs up to a single line.
TMEPRV32	Provider Organization Name for Validation Purposes	Text, no payer data entry needed	**This field is calculated.** It feeds into other formulas in the workbook that produce validation checks. For use by OHA only.

Tab 4. TME_UNATTR – Unattributed Members

Data Element	Name	Type	Description
TMEUNA01	Reporting Year	Year	Year for which data is being reported.
TMEUNA02	Line of Business Code	Integer, from 1 to 6	This field indicates the line of business being reported. 1 = Medicare (Exclude Dual Eligible) 2 = Medicaid (Exclude Dual Eligible) 3 = Commercial: Full Claims 4 = Commercial: Partial Claims 5 = Medicare Expenses for Medicare/Medicaid Dual Eligible 6 = Medicaid Expenses for Medicare/Medicaid Dual Eligible See Line of Business for additional details.
TMEUNA03	Member Months	Positive integer	The number of members enrolled in a plan over the reporting calendar year expressed in months of membership. **Note that if the number of member months is fractional, round it to the nearest integer.**
TMEUNA04	Demographic Score	Positive Number	The weighted average demographic adjustment factor for the member population. See Demographic Adjustment for additional details.
TMEUNA05	Claims: Hospital Inpatient	Number, no negative value	Sum of the allowed amount from the claims for hospital inpatient services. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEUNA06	Claims: Hospital Outpatient	Number, no negative value	Sum of the allowed amount from the claims for hospital outpatient services. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**

Data Element	Name	Type	Description
TMEUNA07	Claims: Professional, Primary Care Providers	Number, no negative value	Sum of the allowed amount from the claims for physicians or physician group practices that defined as a PCP. OB/GYNs are not considered a PCP for this purpose. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEUNA08	Claims: Professional, Specialty Providers	Number, no negative value	Sum of the allowed amount from the claims for physicians or physician group practices that are not defined as a PCP. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEUNA09	Claims: Professional, Behavior Health Providers	Number, no negative value	Sum of the allowed amount from the claims for providers that are defined as behavior health providers. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEUNA10	Claims: Professional, Other Providers	Number, no negative value	Sum of the allowed amount from the claims for health care providers for services provided by a licensed practitioner other than a physician, a physician group, or identified as a PCP. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEUNA11	Claims: Long-Term Care	Number, no negative value	Sum of the allowed amount from the claims for long-term care services. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**

Data Element	Name	Type	Description
TMEUNA12	Claims: Retail Pharmacy	Number, no negative value	Sum of the allowed amount from the claims for the retail pharmacy services. This should not include claims paid for pharmaceuticals under the insurer's medical benefit. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEUNA13	Claims: Other	Number, no negative value	Sum of the allowed amount from the claims for all other services not mentioned above. See Claims Payments by Service Category for additional details. **Note that this allowed amount is not demo-adjusted.**
TMEUNA14	Non-Claims: Prospective Payments	Number, no negative value	Sum of all the non-claims payments from the payer to providers for prospective capitated, prospective global budget, prospective case rate, or prospective episode-based payments. See Non-Claims Payments for additional details.
TMENUA15	Non-Claims: Performance Payments	Number, no negative value	Sum of the non-claims payments from the payer to providers for performance payments. This includes pay-for-performance and pay-for-reporting. See Non-Claims Payments for additional details.
TMENUA16	Non-Claims: Shared Risk and Shared Savings Settlements	Number	Sum of the non-claims payments from the payer to providers for shared risk and shared savings settlements. Note that shared risk recoupments are reported as a negative number, but all other incentive payments that payers pay to providers are positive numbers. This field is the net amount and could be either positive or negative. See Non-Claims Payments for additional details.

Data Element	Name	Type	Description
TMENUA17	Non-Claims: Payments to Support Population Health and Practice Infrastructure	Number, no negative value	Sum of the non-claims payments from the payer to providers to support population health and practice infrastructure. See Non-Claims Payments for additional details.
TMEUNA27	Non-Claims: HSRN	Number, no negative value	Payments made by CCOs for Health-Related Social Needs of their members. See Non-Claims Payments for additional details.
TMENUA18	Non-Claims: Recovery	Number, no positive value	Sum of the non-claims payments from a provider, member/beneficiary or other payer because of a review, audit, or investigation. This field should be reported as a **negative number**. See Non-Claims Payments for additional details.
TMENUA19	Non-Claims: Other	Number, no negative value	Sum of the non-claims payments from the payer to providers that cannot be properly classified elsewhere. See Non-Claims Payments for additional details.
TMEUNA20	Demographic Adjusted Standard Deviation PMPM	Number, no negative value	The standard deviation of demo adjusted TME PMPM. Although payers report unadjusted claims payments, payers must report the demo-adjusted standard deviation of TME PMPM. N **is the number of member months by line of business.**
TMEUNA21	Total Claims Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the allowed amount of claims payments. This is calculated by summing from TMEUNA05 to TMEUNA13. Payers should review for reasonableness.

Data Element	Name	Type	Description
TMEUNA22	Total Non-Claims Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the non-claims payments from the payer to providers. This is calculated by summing from TMEUNA14 to TMEPRV19. Payers should review this field for reasonableness.
TMEUNA23	Unadjusted Total Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the non-adjusted allowed amount of claims and all the non-claims payments from the payer to providers. This is the sum of TMEUNA21 and TMEUNA22.
TMEUNA24	Unadjusted TME PMPM	Number, no payer data entry needed	**This field is calculated.** It is to display the TME per member per month before demo-adjustment. This is calculated by dividing TMEUNA23 by TMEUNA03.
TMEUNA25	Demographic Adjusted Total Expenses	Number, no payer data entry needed	**This field is calculated.** It is to display all the demo-adjusted allowed amounts of claims and all the non-claims payments from the payer to providers. This is calculated by dividing TMEUNA21 by TMEUNA04 and then adding it to TMEUNA22.
TMEUNA26	Demographic Adjusted TME PMPM	Number, no payer data entry needed	**This field is calculated.** It is to display demo-adjusted TME per member per month. This is calculated by dividing TMEUNA25 by TMEUNA03.

Tab 5. MARKET_ENROLL - Market Enrollment Data

Data Element	Name	Type	Description
MED01	Market Enrollment Category	Fixed text, no payer data entry needed	**No payer data entry needed.** This field indicates the market segment being reported. The market segments include 1. Large group fully insured (51 + employees) 2. Small group fully insured (2 – 50 employees) 3. Self-insured 4. Individual (buy coverage on their own) 5. Student plans 6. Medicare Advantage 7. Medicaid Managed Care 8. Medicare Medicaid duals
MED02	Year 2023 Member Months	Positive integer	This field indicates in 2023, the number of enrolled in a plan over the reporting calendar year expressed in months of membership. **Note that if the number of member months is fractional, round it to the nearest integer.**
MED03	Year 2024 Member Months	Positive integer	This field indicates in 2024, the number of members enrolled in a plan over the reporting calendar year expressed in months of membership. **Note that if the number of member months is fractional, round it to the nearest integer.**

Tabs 6-7. Medical Pharmacy Claims

Data elements are almost the same as for Tabs 3-4, except that they exclude non-claims fields, and a few Medical pharmacy validation checks in the RX_MED_PROV tab (Tab 6). Validation columns in RX_MED_PROV are listed below; all other fields contain parallel information to that in the TME_PROV tab for RX_MED_PROV and the TME_UNATTR tab for RX_MED_UNATTR.

Data Element	Name	Type	Description
TMERXPRV15	Is the combination of Year-LOB-Provider-IPA-Attribution in TME_PROV?	Text, no payer data entry needed	**This field is calculated.** It is to identify lines where a given combination of Year-LOB-Provider-IPA-Attribution Hierarchy Code is not present in TME_PROV, which would indicate a validation concern.
TMERXPRV16	Check for unique combination of Year-LOB-Provider-IPA-Attribution	Text, no payer data entry needed	**This field is calculated.** It is to identify duplicate entries at the Year-LOB-Provider Name-IPA/Contract Name – Attribution Hierarchy Code level. All costs should be rolled up at this level so data submitters should identify any rows that say “Duplicate Row” and roll all costs up to a single line.
TMERXPRV17	Provider Organization Name for Validation Purpose	Text, no payer data entry needed	**This field is calculated.** It feeds into other formulas in the workbook that produce validation checks. For use by OHA only.

Tab 8. RX_REBATES - Pharmacy Rebates

Data Element	Name	Type	Description
RXR01	Reporting Year	Year	Year for which data is being reported.
RXR02	Line of Business Code	Integer, from 1 to 6	This field indicates the line of business being reported. 1 = Medicare (Exclude Dual Eligible) 2 = Medicaid (Exclude Dual Eligible) 3 = Commercial: Full Claims 4 = Commercial: Partial Claims 5 = Medicare Expenses for Medicare/Medicaid Dual Eligible 6 = Medicaid Expenses for Medicare/Medicaid Dual Eligible See Line of Business for additional details.
RXR07	Provider Organization Name (Optional)	Free text, blank is allowed	**This is an optional field** to indicate the full name of the provider organization that the pharmacy rebates are attributed to.

Data Element	Name	Type	Description
RXR03	Medical Pharmacy Rebate Amount	Number, no positive value	The value of total federal and state supplemental rebates attributed to Oregon resident members provided by pharmaceutical manufacturers for prescription drugs that are administered by medical providers. This amount should include pharmacy benefit manager (PBM) rebate guarantee amount and any additional rebate amount transferred by the PBM. This field should be reported as a **negative number**.
RXR04	Retail Pharmacy Rebate Amount	Number, no positive value	The value of total federal and state supplemental rebates attributed to Oregon resident members provided by pharmaceutical manufacturers for prescription drugs that are administered by retail pharmacy. This amount should include pharmacy benefit manager (PBM) rebate guarantee amount and any additional rebate amount transferred by the PBM. This field should be reported as a **negative number**.
RXR05	Total Pharmacy Rebate Amount (optional)	Number, no positive value	**This is an optional field** to display the total pharmacy rebate amount only if payers are unable to separately report medical and retail pharmacy rebates in RXR03 and RXR04. If this field is used, RXR03 and RXR04 should be blank.
RXR06	Total Pharmacy Rebate Amount	Number, no payer data entry needed	**This field is calculated.** It is to display the total pharmacy rebate amount. It is the sum of RXR03 and RXR04. Payers should review for reasonableness.

Tab 9. PROV_ID - Provider Organization Information

Data Element	Name	Type	Description
PRV01	Provider Organization Name	Text	Indicates the full name of the provider organization listing in Tab 3. TME_PROV. Note that the same provider organization name can be reported into multiple rows if it has multiple identifiers to be reported.
PRV02	Provider Organization TIN	Text, 9 digits including leading zero	Indicates the provider federal taxpayer identification number for the provider organization that is reported. TINs should be reported as 9 digits, including leading zeros but not including dashes, e.g., 012345678.
PRV03	IPA or Contract Name (optional)	Text, blank is allowed	This is an optional field to indicate the name of the IPA or contract group a member is included in.

Appendix C: Provider Taxonomy

Professional – Primary Care Providers

Taxonomy Code	Description
364S00000X	Certified clinical nurse specialist
261QF0400X	Federally qualified health center
175L00000X	Homeopathic medicine
175F00000X	Naturopathic medicine
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health
363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatrics
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
163W00000X	Nurse, non-practitioner
207Q00000X	Physician, family medicine
207R00000X	Physician, general internal medicine
208D00000X	Physician, general practice
207RG0300X	Physician, geriatric medicine
202D00000X	Physician, integrative medicine
208000000X	Physician, pediatrics
2083P0500X	Physician, preventive medicine
363A00000X	Physician's assistant/associate
363AM0700X	Physician's assistant/associate, medical
261QP2300X	Primary care clinic
261QR1300X	Rural health clinic

Note psychiatric and OB/GYN providers are included in the primary care spending reporting program's definition but have been excluded from the provider taxonomies above for the purposes of the Cost Growth Target Program's taxonomy for attribution.

At the June 9, 2021 Technical Advisory Group meeting, payers requested more guidance in identifying Professional: Primary Care Providers using procedure codes. The table below lists primary care procedure codes from the Primary Care Spending Reporting Program's definition. OB/GYN related services have been excluded for the purposes of the Cost Growth Target Program.

OHA recommends care in use because these codes from the Primary Care Spending Reporting program are a narrow set and payers may have procedures in their own data that make sense to them to identify primary care services but are not listed in the table below.

Primary Care ICD-10 Codes:	Description
Z00	Encounter for general exam without complaint
Z000	Encounter for general adult medical examination
Z0000	Encounter for general adult medical exam without abnormal findings
Z0001	Encounter for general adult medical exam with abnormal findings
Z001	Encounter for newborn, infant and child health examinations
Z0011	Newborn health examination
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z0012	Encounter for routine child health examination
Z00121	Encounter for routine child health exam with abnormal findings
Z00129	Encounter for routine child health exam without abnormal findings
Z008	Encounter for other general examination

Primary Care CPT Codes:	Description
G0008-G0010	Administration of influenza virus, pneumococcal, hepatitis B vaccine
G0396-G0397	Alcohol or substance abuse assessment
G0438-G0439	Annual wellness visit, personalized prevention plan of service
G0442	Annual alcohol screening
G0445	Brief behavioral counseling for alcohol misuse
G0444	Annual depression screening
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services

Primary Care CPT Codes:	Description
G0513-G0514	Prolonged preventive service
90460-90461	Immunization through age 18, including provider consult
90471-90471	Immunization by injection
90473-90474	Immunization by oral or intranasal route
96160-96161	Administration of health risk assessment
964372	Therapeutic, prophylactic or diagnostic injection
98966-98968	Non-physician telephone services
98969	Online assessment, management services by non-physician
99201-99205	Office or outpatient visit for a new patient
99211-99215	Office or outpatient visit for an established patient
99241-99245	Office or other outpatient consultations
99339-99340	Physician supervision of patient in home or rest home
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99387	Preventive medicine initial evaluation
99391-99397	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counseling or risk reduction intervention
99406-99407	Smoking and tobacco use cessation counseling visit
99408-99409	Alcohol or substance abuse screening and brief intervention
99411-99412	Group preventive medicine counseling or risk reduction intervention
99429	Unlisted preventive medicine service
99441-99443	Telephone calls for patient management
99444	Non face-to-face online medical evaluation
99483	Cognition and functional assessment
99484	Care management services for behavioral health conditions
99492	Initial psychiatric collaborative care management
99493	Subsequent psychiatric collaborative care management
99494	Initial or subsequent psychiatric collaborative care management
99495-99496	Transitional care management services

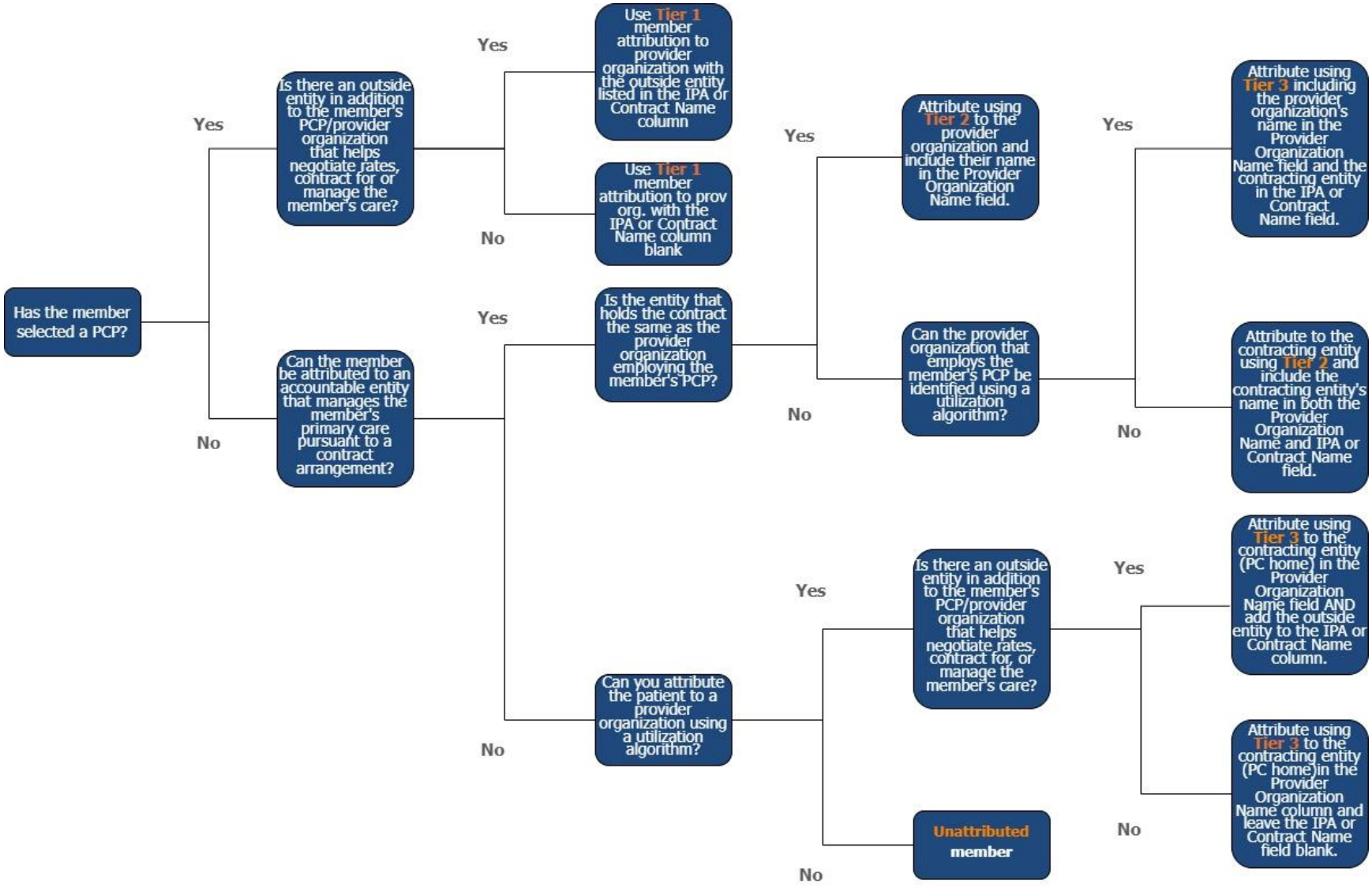
Professional – Behavioral Health Providers

At the June 9, 2021 Technical Advisory Group meeting, payers indicated it would be helpful to have, in addition to the provider taxonomy codes, a set of procedure codes that they could have the option of using to help identify professional behavioral health providers. The supplemental code set linked below provides behavioral health procedure codes from Oregon's Health Evidence Review Commission (HERC) approved Prioritized List. Payers are not required to use these codes if they have in-house methodology for identifying professional behavioral health services.

OHA recommends care in use because payers may have procedures in their own data that make sense to them to identify professional behavioral health services but are not listed in the supplemental code set.

See supplemental code set for behavioral health providers posted online at: https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

Appendix D: Attribution and Contracting Diagram



Appendix E: Medical Pharmacy Codes

A list of medical pharmacy HCPCS/CPT codes (csv file) for use in pulling medical pharmacy costs can be found in attachment to this manual on the CGT data submission website and will be updated annually by OHA. Please see the section on Tabs 6-7 related to Medical pharmacy for instructions on how to incorporate this list into logic for identifying medical pharmacy claim lines.

Appendix F: Glossary

Definitions

Allowed Amounts: refers to the maximum allowed charge for a covered benefit, which includes both the amount paid by the insurer to the provider and the patient liability owed directly to the provider, regardless of whether the patient actually paid the owed amount; this is also known as the negotiated rate, or the contract rate. The full allowed amount is reported, regardless of whether stop loss/reinsurance policies are applied. The allowed amount is not necessarily the sum of what the provider organization is paid.

Claims Payments: all the allowed amounts on provider claims to payers, including the amount payers paid to providers and any member cost sharing, including copayments, deductibles, and co-insurance.

Cost Sharing: includes patient liability, such as copayments, deductibles and co-insurance payments recorded by payers.

Independent Practice Association or Independent Physician Association (IPA): a network of physician practices organized with the intention of sharing business expenses and pursuing shared business ventures.

Line of Business (LOB): different product types offered within and across a market. For example, the commercial market includes the individual, self-insured, large group and small group lines of business. Line of Business has more specificity than Market (see below) although they are sometimes used interchangeably.

Market: the highest levels of categorization of the health insurance market. For example, traditional Medicare and Medicare Advantage are collectively referred to as the "Medicare Market" and Medicaid Fee for Service and Medicaid Coordinated Care Organizations are collectively referred to as the "Medicaid Market." Individual, self-insured, small and large group, and student health insurance plans are collectively referred to as the "Commercial Market."

Measurement Year: the calendar year (Jan 1 – Dec 31) for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.

Net Cost of Private Health Insurance (NCPHI): captures the cost to Oregon residents associated with the administration of private health insurance. It is the difference between health premiums earned and claims paid. It consists of payers' costs related to paying bills, advertising, sales commissions, other administrative costs, premium taxes, and other fees. It also includes payers' profits (contribution to margin) or losses.

Non-Claims Payments: all payments that payers make to providers other than providers' claims. This includes incentive payments, prospective payments for health care services (e.g., capitation), payments that support care transformation and infrastructure (e.g., care manager payments, lump sum investments, patient centered primary care home payments) and other payments that support provider services.

Paid Amounts: refers to the actual dollar amount paid by the insurer to the provider. For TME data reporting, claims expenses reported under dual eligible LOB codes 5 and 6 are reported using Paid Amounts regardless of whether the payer is the primary or secondary payer.

Payer: a public or private organization or entity that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicaid, and/or Medicare managed care. Also referred to as insurance carriers or carriers.

Pharmacy Rebates: any rebates from pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees. TME is reported net of pharmacy rebates.

Provider Organization: an organization with primary care providers that meets the established size threshold for public reporting of performance relative to the cost growth target.

Total Cost of Care Contract (TCOC): a contract with a per member per month payment established between a provider entity and a payer with the goal to encourage associated primary care providers to identify at-risk members and use established networks to manage and deliver care.

Total Health Care Expenditures (THCE): the total medical expense incurred by Oregon residents for all health care services for all payers reporting data, plus the insurers' Net Cost of Private Health Insurance.

Total Medical Expense (TME): the sum of the allowed amount of total claims and total non-claims spending paid to providers for all health care services delivered to Oregon residents. TME is reported at multiple levels: state, market, payer, and provider organization. TME is reported net of pharmacy rebates at the state, market, and payer levels only. Payers report TME by line of business (e.g., individual, self-insured, large group, small group, Medicare, Medicaid, etc.) and at the provider organization level wherever possible. Only allowed amounts from final, paid claims should be included; TME should exclude claims that have been denied or are in an adjudication process.

Value-Based Payments (VBP): payments to provider entities that explicitly reward the value that can be produced through the provision of health care services to members. These arrangements can exist anywhere from FFS payments with additional payments to a fully integrated population-based payment.